

KK4001

# **REGULATIONS AND PROCEDURE**

**VETERANS ADMINISTRATION**

**WASHINGTON, D. C.**



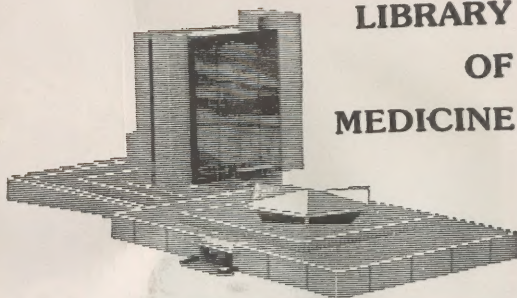
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## MEDICAL AND HOSPITAL SERVICE

### CENTRAL OFFICE

#### THE MEDICAL COUNCIL

6000. PURPOSE OF MEDICAL COUNCIL.—The Medical Council, Veterans Administration, was established with a view to improving the care and treatment of beneficiaries. Composed of medical specialists and other consultants, the medical council serves in an advisory capacity to the Administrator, in matters of medicine, medical administration, statistics, operation of hospital facilities, dispensaries, etc. The services of the members of the medical council are utilized through conferences in central office, upon dates set as occasion requires; through correspondence of the medical director, related to submitted questions of policy, procedure, etc.; and through inspection visits of council members to field stations upon requests of the Administrator, through the medical director. Managers, chief medical officers or other personnel in facilities or regional offices have no authority to request opinion directly from the medical council or any individual member thereof. (January 6, 1936.)

#### MEDICAL AND HOSPITAL SERVICE SUPERVISORS

6001. (A) Assignment.—There will be assigned to the medical and hospital service, physicians and dentists, to be designated medical and hospital service supervisors, who will be under the jurisdiction and direction of the medical director.

(B) Duties.—The duties of such supervisors will be the study, inspection, and corrective correlation of medical, including dental, activities in regional offices, and facilities of the Veterans Administration. Upon request, such supervisors may be detailed for temporary duty with the investigation division, in connection with investigation activities of a medical nature.

(C) Authority.—Medical and hospital service supervisors are authorized to take appropriate remedial action on medical matters assigned for their disposition by the medical director, invited to their attention by officers of field stations, or disclosed during their tours of duty. All such action will be taken in accordance with accepted medical policy and procedure. In all medical matters involving new policy or procedure of a medical nature, they will not take remedial action until so instructed by the medical director, to whom they will refer their comment and recommendations on the subject in question. In visiting facilities, such supervisors will discuss personal service rendered patients, and will advise and assist in securing attention to such personal service as is not rendered by other agencies and which the Veterans Administration is authorized to undertake.

(D) Official Station.—The official station of the medical and hospital service supervisors will be central office, Washington, D. C. While supervisors are working in field stations the necessary desk space and stenographic help will be furnished them.



(E) Travel Orders.—All travel of supervisors will be authorized from the central office upon request of the medical director, who will outline itineraries for such travel. While in travel status, supervisors will be allowed, in addition to their travel expense, per diem in lieu of subsistence, in accordance with Standardized Government Travel Regulations.

(F) Reports.—Medical and hospital service supervisors will render reports on all action taken by them as soon as possible after such action. These reports will be in triplicate. One copy will be furnished to the head of the field station concerned. The original and one copy will be forwarded to the medical director. When detailed for duty with the investigation division, they will send the original report and copy to the chief of that division. The head of the station concerned will take appropriate action on the recommendations of supervisors within 10 days after receipt of the copy thereof, forwarding a report of such action, and any comment he desires to add, to the medical director. When medical and hospital service supervisors recommend to the medical director action on new policy or procedure they will furnish the station head concerned with a copy of such recommendation, and if the station head wishes to comment upon the recommendation the supervisor will forward such comment with the original of his recommendation to the medical director. Any order given to a station head by a supervisor, intended to secure correction of ascertained defects of approved procedure or departures from approved policy, must be clear, full, and in writing. An original and one copy of such orders will be prepared. Both will bear the signature of the medical service supervisor and be dated. The original will be personally delivered to the station head. The copy will be attached to the supervisor's general report on the station which is forwarded by him to the medical director, after it has been signed by the station head who will, by such signature, acknowledge delivery of the original order to him. If during a visit to a field station, a supervisor discovers a situation which appears to have an investigative aspect, he will promptly report the facts with his comment to the medical director, who will determine their relative gravity and will either instruct correction by administrative measures within his authority, or refer the data with his recommendation for disposition through the investigation division.

[ ] (April 25, 1942.)

[6003 canceled April 25, 1942. (See R. & P. 4)]

[6004 canceled April 25, 1942. (See R. & P. 814)]



## UNIFORMS OF PERSONNEL AT FACILITIES.

6005. OFFICERS REQUIRED TO WEAR A UNIFORM.--[The manager, domiciliary officer, commissary officer, utility officer, or assistant officers in those positions; supply officer, adjudication officer, chief attorney, finance officer (male), vocational rehabilitation officer], chaplain, and medical and dental officers, full time, while on duty at facilities will be dressed in accordance with one of the uniform combinations herein described; provided that the selection of the combination to be worn for the season, day or occasion will be ordered by the manager, and the dress for all officers must be of the same type for the same season, day or occasion. When any officer specified herein has to perform a duty for which the wearing of a uniform is inappropriate, he may, upon consent of the manager, wear other work clothing during such duty. (December 15, 1943.)

6006. COMBINATIONS OF UNIFORMS.--The uniform of the season, day or occasion will be selected from one of the following combinations:

(A) Double-breasted navy blue serge, mohair or basket weave fabric coat, and long trousers of the same material and color as the coat. The wearing of a vest of the same material and color as the coat will be optional with the wearer. A white shirt, white collar, black four-in-hand tie, black shoes and black socks; and a blue or white cap, as ordered by the manager, will be worn with this combination.

(B) Same coat as (A), white flannel, white serge, white linen or white duck trousers, white shirt, white collar, black four-in-hand tie. With this combination, either black shoes and black socks, or white shoes and white socks, may be worn as ordered. The white cap will be worn with this combination.

(C) While on ward, laboratory or clinic duty, medical and dental officers will wear a white smock in place of the blue service coat. (April 25, 1942.)

6007. SPECIFICATIONS.--[Compliance with the following specifications in the procurement of officers' uniforms will be conditioned by current orders of the War Production Board. If any material, such as serge of the prescribed weight, cannot be obtained, a substitute of the specified color and cut may be worn.]

(A) Double-breasted sack coat, three buttons down each fore part, seamed back, no vent, semi-fitting; length, reaching about 1 inch below crotch line; rolling collar; to be worn buttoned, using three buttons on the right side. Material: Dark navy blue serge (navy standard serge) 14 ounce; authorized variation 12 to 16 ounces or mohair or basket weave fabric, dark navy blue.

(B) Vest of same material as coat; design optional with wearer.

(C) Trousers, blue material, same as for service coat; to be worn with either belt or suspenders.

(D) Trousers, white, long. Material: plain bleached linen duck, union duck or cotton duck. Navy standard drill  $6\frac{1}{4}$  ounces per linear yard will be satisfactory; to be worn with either belt or suspenders. White flannel trousers will be of good quality plain flannel. White serge trousers of good quality may be worn instead of flannel.

(E) Cap, blue or white. The frame must be so constructed that a blue cloth or white duck cover may be fitted. In general, the measurements, with the cover on, should be: Length of crown, about 10 inches; width, about  $9\frac{1}{2}$  inches; height in rear, from bottom of frame,  $2\frac{1}{4}$  inches; in front, from visor to top,  $3\frac{1}{4}$  inches. The cap will have at the junction of the visor a  $\frac{6}{8}$  inch gold strap with a  $\frac{1}{16}$  inch



stripe (red for medical officers, dark navy blue for others), through the center. This strap will be attached to small brass bell buttons at the side of the cap. The visor will be black, not embroidered. Affixed to the front of the cap will be an ornament bearing an enlarged design, without lettering, of the Veterans Administration seal as appearing upon official stationery. No insignia of any nature or description will be worn by medical or dental officers, except as provided under specifications for the cap.

(F) Shirts; plain white material with plain white cuffs, made in coat style with not less than five buttons.

(G) Collar; plain white material, stiff and starched, turned-down style. Soft plain white material collars, attached or unattached to shirt may be worn at the option of the wearer.

(H) Neckwear; neckties will be plain black four-in-hand.

(I) Shoes; black shoes, high or low; will be laced and worn when blue trousers are prescribed, and may be worn with white trousers. White shoes of canvas or skin, the same style, as black leather shoes, will be worn only with white trousers.

(J) Socks, white or black, will be of plain material undecorated.

(K) Smocks; made to button over shoulder and under arm entire length of right side; snug fitting; V-neck; one patch pocket; plain back, length approximately 4 inches above knee; full-length sleeves. Material, plain white twill.

[(L) Campaign ribbons, service sleeve stripes, and decorations may be worn with officers' uniforms.] (December 15, 1943.)

6008. UNIFORM FOR NURSES.--[Uniforms purchased by nurses for wear while on duty in facilities, will conform as follows to General Limitations Order L-85, War Production Board:]

(A) White material, new fitted model with waist line; [length and sweep to accord with Schedule N, Order L-85, War Production Board; 3-inch hem; box pleat in front, 2½ inches wide; link cuffs, 2 inches wide two buttonholes, 1 inch from edge of cuff;] three buttonholes on front of waist, to be 5 inches apart; detachable belt, 2 inches wide, with two small pearl buttons on belt, 1 inch apart; two deep patch pockets.

(B) White shoes and white hose.

(C) Cap of medium grade India linen. Chief nurses will wear a black velvet band, one-half inch in width, and head nurses a black velvet band, one-eighth inch in width, on caps.

(D) Cape - Nurses whose status is permanent will provide themselves with a uniform cape for outdoor use while on duty. The following are specifications for this uniform cape:

(1) Material.--Dark blue serge, 14-ounce weight, lined with 10-ounce scarlet flannel, all wool guaranteed sponged to prevent spotting and shrinkage.

(2) Design.--Cut military style, darts on shoulders, seam down back. Modified storm collar, 4 inches wide in front, 4½ inches wide in back, with built-in stand in back, with 6 rows of stitching ½ inch apart in back, to ½ inch apart in front or brought into a space approximately ½ inch wide where one japanned hook and eye is used for fastening. Collar is to be rounded on corners in front. Length of cape is to be 16 inches from the floor. Cape is to be approximately 2½ yards around bottom, or in proportion to bust measure. Cape to lap in front 1½ inches each side of center line in front.



(3) Closing.—In addition to one japanned hook and eye at neck, one naval a griffe in front, sewed on 7 inches below neck, said a griffe to be made of best quality mohair ( $\frac{1}{4}$  inch square) 4 cord square, looped on ends, in double trifoil design 2 by  $2\frac{1}{4}$  inches and to have one  $1\frac{1}{4}$  inch mohair basket-weave (woven) olive at each end, to fasten over loops on ends to make a complete fastening. The entire a griffe to measure, when fastened  $10\frac{1}{2}$  inches end to end.

(4) Construction.—Both serge and scarlet lining to be sewed with best quality black sewing thread (silk, if procurable). Double stitched shoulder darts; double stitched back seams; and single stitched all around edge of cape  $3/16$  inch from edge. Collar to have fine linen canvas lining on inside, stitched in points underneath, 2 inches at base to point on edge. Nurse's initials in yellow (silk, if procurable) on black base, on back, inside, just below collar. One black japanned chain (hanger) to be strongly sewed into base of collar in back. (December 15, 1943.)

6009. UNIFORM FOR DIETITIANS.—[Uniforms purchased by dietitians for wear while on duty in facilities, will conform as follows to General Limitations Order L-85, War Production Board:

(A) White princess model made of shrunk material, having a four gore front and a three gore back, the center front gores beginning at center of shoulder seam and not less than  $4\frac{1}{4}$  inches wide at waist line when finished, flaring at bottom of skirt finished. The back center gore side seams will meet the two center front gore side seams at center of shoulder seam. The back center gore will be not less than eight inches wide at waist line finished, and will flare at bottom of skirt when finished. A roll collar  $4\frac{1}{2}$  inches wide at center back, notched in  $1\frac{1}{4}$  inches, will be inserted under a five-eighths inch double bias fold of good quality material. There will be a single pleat  $1\frac{1}{2}$  inches wide down center front. The sleeves will be long, one-piece, with cuffs,  $2\frac{3}{4}$  inches wide, having two size 24 button holes in each cuff; sleeve opening to be finished with outside placket  $1\frac{1}{2}$  inches wide and six inches long folded to point end, with bar seam across end of opening. The waist front will be closed with six detachable ocean pearl buttons, half fine or better quality, ligne 24, arranged in two groups of three each, the groups to be  $2\frac{3}{4}$  inches apart, or less if necessary, to have six buttons above the belt in short waist uniforms. The skirt front will be closed down under pleat from top line of pockets. A detachable belt of the same material as the uniform will be two inches wide, overlapping in front  $6\frac{1}{2}$  inches, with two detachable ocean pearl buttons, ligne 24,  $4\frac{1}{2}$  inches apart. There will be two patch pockets six inches wide finished, center length finished  $6\frac{1}{2}$  inches to point, stitched hem at top, placed on side front gores below waist line, and one breast pocket  $3\frac{1}{2}$  inches wide, center length finished four inches to point, stitched hem at top, placed to center on left gore seam. Belt loops will be placed so as to hold the belt at normal waist line. The bottom of the uniform will be finished with a three-inch hem, the length and sweep of uniform to comply with War Production Board General Limitations Order L-85, Schedule N.]

(B) Cap.—Medium grade organdie; front made double, measuring  $6\frac{1}{4}$  inches wide and  $15\frac{1}{2}$  inches long when finished, folding back to form a band  $3\frac{1}{4}$  inches wide. From front to back of cap, with band folded, will measure  $7\frac{1}{4}$  inches. Chief dietitians will wear a Delft blue velvet band, one-half inch wide, and head dietitians will wear a Delft blue velvet band, one-eighth inch in width, on caps.

(C) White shoes and white hose.



(D) Cape.--Dietitians whose status is permanent will provide themselves with a uniform cape for outdoor use while officially on duty, this cape to be worn with the official dietitian's uniform only. The following are specifications for the uniform cape:--

(1) Material.--Cadet gray 14-ounce all-wool kersey, lined with 12-ounce Copenhagen blue all-wool flannel, guaranteed sponged to prevent spotting and shrinkage.

(2) Design.--Cut military style, darts on shoulders, seam down back, modified storm collar, 4 inches wide in front,  $4\frac{1}{2}$  inches wide in back, with built-in stand in back, with 6 rows of stitching  $\frac{1}{4}$  inch apart in back, to  $\frac{1}{8}$  inch apart in front or brought into a space approximately  $\frac{1}{2}$  inch wide where one japanned hook and eye is used for fastening. Collar to be rounded on corners in front. Length of cape to be 16 inches from the floor. Cape is to be approximately  $2\frac{3}{4}$  yards around bottom, or in proportion to bust measure. Cape to lap in front  $1\frac{1}{2}$  inches each side of center line in front.

(3) Closing.--In addition to one japanned hook and eye at neck, one naval a griffe in front, sewed on 7 inches below neck, said a griffe to be made of best quality mohair ( $\frac{1}{4}$  inch square) 4 cord square, looped on ends, in double trifoil design 2 by  $2\frac{1}{4}$  inches and to have one  $1\frac{1}{2}$  inch mohair basket-weave (woven) olive at each end, to fasten over loops on ends to make complete fastening. The entire a griffe to measure, when fastened  $10\frac{1}{2}$  inches end to end.

(4) Construction.--The cadet gray kersey and the Copenhagen blue flannel lining to be sewed with best quality sewing thread (silk, if procurable) -- gray on outside, and blue on lining. Double stitched shoulder darts; double stitched back seam; and single stitched all around edge of cape  $\frac{3}{16}$  inch from edge. Collar to have fine linen canvas lining on inside, stitched in points underneath, 2 inches at base to point on edge. Dietitian's initials in yellow (silk, if procurable) on black base, on back, inside, just below collar. One black japanned chain (hanger) to be strongly sewed into base of collar in back. (December 15, 1943.)

6010. UNIFORM FOR OCCUPATIONAL THERAPY AND [PHYSICAL THERAPY PERSONNEL.--Uniforms purchased by personnel of these classes, for wear while on duty in facilities, will conform as follows to General Limitations Order L-85, War Production Board]:

(A) The material will be white pre-shrunk "Indian Head" nurses' linen, twill, poplin, broadcloth, pique or similar material. Modified princess model; sport collar, buttoning to 5 inches below the waist, with four or five 24-ligne detachable pearl buttons, 4 inches apart. The opening in front will end in a 1-inch center guimpe pleat. The front will have a semi-yoke effect, with two side panels or fillers, stitched from below the arms, with  $\frac{1}{4}$  inch stitching all around, extending to bottom of skirt. The center between the fillers will have a total width of  $9\frac{1}{2}$  inches, when buttoned. [There will be two patch pockets 6 inches wide finished, center length finished  $6\frac{3}{4}$  inches to point, stitched at top, placed below the waist line, with  $\frac{1}{4}$  inch stitching. Sleeves will have cuffs  $2\frac{3}{4}$  inches wide, having 2 size 24 buttonholes in each cuff; sleeve opening to be finished with outside placket  $1\frac{1}{2}$  inches wide and 6 inches long folded to point and with bar seam across end of opening. They may be long or short, whichever is suitable for the climate. Two loops will hold at normal waist line a detachable belt 2 inches wide, with two removable buttons. The uniform will be finished with a hem at the bottom of the skirt at least 3 inches in width. The skirt will be flared to a width of not less than 62 inches for size 32 at the bottom, when hemmed; other sizes and length in accordance with War Production Board General Limitations Order L-85, Schedule N.]



(B) White shoes and white hose. [ ]

(C) A blue smock is approved for occupational therapy aides to be worn over the white uniform when needed. The smock will conform to the following specifications: It will be made of fast blue "Indian Head" or similar material and will have full-length opening with removable 30-ligne pearl buttons approximately  $4\frac{1}{2}$  inches apart, V-shaped neck, collarless to fit under the collar of the white uniform, giving the effect of a blue smock with white collar. The sleeves will end in a single cuff buttoned. It will have two patch pockets with  $1\frac{1}{2}$  inch hem, one-quarter inch stitching. The length of the smock will be 2 inches shorter than the white uniform.

(D) Cap of medium grade white India linen. The front will be made double. The chief aide will wear 3, and head aides 2 navy blue stripes, embroidered on the cap with mercerized two-ply floss. These stripes are to be  $2\frac{1}{2}$  inches long,  $\frac{1}{4}$  inch wide, and  $\frac{1}{4}$  inch apart, the top stripe to be 2 inches from the point of the cap.

(E) Male [physical therapy technicians] will wear either white trousers and white shirt with black tie (furnished at their own expense), or white smocks (furnished by the Government), whichever is determined by the manager as preferable. (December 15, 1943.)

6011. UNIFORM FOR LIBRARIANS.--[Male librarians are not required to wear a uniform. Uniforms purchased by female librarians for wear while on duty in facilities, will conform as follows to General Limitations Order L-85, War Production Board:

(A) White, one-piece semi-form-fitting model of shrunk material with turnover, wing collar, V-neck center front opening, detachable belt, full length sleeves with cuffs, or short sleeves if preferred, two patch pockets on skirt and one breast pocket. The measurements given are for size 38 uniform. (Collar): The collar will be  $3\frac{1}{4}$  inches wide center back and  $2\frac{1}{2}$  inches wide in front, made of two-ply material turned and single stitched. (Front): The front opening will be 14 inches long from the collar seam; right side to be finished with an outside facing  $1\frac{1}{2}$  inches wide stitched at both edges and ending in a point  $15\frac{1}{2}$  inches from the collar seam. Each side will have an inner facing stitched into collar seam and extended to stitch into shoulder seam  $1\frac{1}{2}$  inches. Five flat, removable, ocean pearl buttons  $\frac{3}{4}$  inch in diameter, close the front and will be evenly spaced from the V-neck opening. (Pockets): Two patch-pockets  $5\frac{1}{2}$  inches wide by  $5\frac{1}{2}$  inches deep at edge (rounded at bottom to 6 inches in depth) will be finished with  $1\frac{1}{2}$  inch outside facing single stitched and placed 4 inches below the normal waist line and 2 inches from the side joining seams. From center of lower side of each pocket to the bottom of skirt a 3-inch inverted box pleat extends. On left side of waist will be placed one patch pocket  $3\frac{1}{2}$  inches wide by  $3\frac{3}{4}$  inches deep at edge rounded at bottom to 4 inches to conform in shape and finish with pockets on skirt. (Back): The back will have a yoke with two points, curved between; the points extending on a diagonal line 4 inches from sleeve seam. Yoke extends over shoulders in front  $1\frac{1}{2}$  inches and is finished with two rows of stitching  $\frac{1}{4}$  inch apart. A single row of stitching will finish yoke in back. There will be two vertical line darts on each side extending above and below the waist line. Outside darts are  $5\frac{1}{2}$  inches from side joining seam; inside  $4\frac{1}{2}$  inches apart; darts to be adjusted as needed for shaping. (Sleeves): Armhole, under arm and shoulder seams will be double stitched not less than  $\frac{5}{32}$  of an inch. The full length sleeves will have an opening extending 4 inches from cuff, finished with a placket 1 inch wide on the outside, pointed at end, and stitched across the width at opening; finished placket to be  $5\frac{1}{2}$  inches long from cuff to point. Under side of opening will be finished  $\frac{7}{8}$  inch. (Cuffs): The cuffs of the long sleeves will be made of two-ply material,



2 inches deep and will be single stitched  $\frac{1}{4}$  inch on outside edges. Each cuff will have two buttonholes for use with cuff links to match buttons of uniform. Short sleeves will end immediately above the bend of the elbow and be finished with a  $1\frac{1}{2}$  inch outside facing, single stitched. (Belt): The belt will be lap-over type  $1\frac{1}{2}$  inches wide finished, single stitched on both edges, top side to end in a point. The lap-over is 4 inches from center to center of two flat, detachable, ocean pearl buttons  $\frac{3}{4}$  inch in diameter. Two belt loops, made double thickness, 2 inches long and  $\frac{1}{4}$  inch wide will be stitched to each side seam at natural waist line. (Buttonholes): The front placket will have vertical buttonholes of suitable size for  $\frac{3}{4}$  inch buttons; the first to be  $4\frac{1}{4}$  inches below collar seam. The belt will have two buttonholes. (Width): The skirt, with a finished hem 3 inches deep, will measure not less than  $1\frac{3}{4}$  yards at the bottom edge. The finished garment will measure not less than 44 inches from the nape of the neck, in compliance with Schedule N of General Limitations Order L-85.]

(B) A smock is approved to be worn over the white uniform when shelving books or doing similar work. The smock will be made of fast-color reseda green material and will have full-length front opening, surplice style; the V-shaped neck collarless, to fit under the white collar of the uniform and finished with an outside bias facing  $1\frac{1}{2}$  inches wide. The right side of the front will be lapped 6 inches over the left side and closed with four detachable pearl buttons  $\frac{3}{4}$  inch in diameter; the first of these to be placed to meet the buttonhole made in the end of right side neck facing, the second 4 inches below the first and the other two placed parallel  $2\frac{1}{2}$  inches from center front, giving a double breasted effect. Buttonholes will correspond. The sleeve will end in a  $1\frac{1}{2}$  inch band, stitched on, and closed with one detachable pearl button. [The smock will have two patch pockets, will be 2 inches shorter than the white uniform and finished with a  $2\frac{1}{4}$  inch hem.]

(C) The uniform and smock may be obtained from any manufacturer whose products meet the requirements outlined.

(D) Librarians will be expected to present a neat appearance at all times. White duty shoes and white hose will complete the uniform. No cap will be worn.

(E) Clerks or other classes of personnel connected with work in facility libraries, but not duly certified as librarians or assistant librarians, will not wear the uniform or smock specified for librarians. (December 15, 1943.)

6012. UNIFORM FOR DENTAL HYGIENISTS AND DENTAL ASSISTANTS.--[Uniforms purchased by dental hygienists and dental assistants, for wear while on duty in facilities, will conform as follows to General Limitations Order L-85, War Production Board:

(A) White material, new fitted model with waist line, length and sweep to accord with Schedule N, Order L-85, War Production Board; 3-inch hem; box pleat in front,  $2\frac{3}{4}$  inches wide; link cuffs, 2 inches wide; three buttonholes on front of waist, 5 inches apart; detachable belt, 2 inches wide, with two small pearl buttons on belt, 1 inch apart; two deep patch pockets.]

(B) White shoes and white hose.

(C) Cap - White nurses cloth, cut 17 inches straight across the front face with depth of 13 inches from front to back; side measure  $8\frac{1}{2}$  inches from front to point; 5 inches from point to angle between side and back, and  $4\frac{1}{4}$  inches from angle to back edge, which is 6 inches wide. The hem is to be 1 inch wide all around; two line two hole fish-eye buttons at each corner of back, with a buttonhole to fit at each back point of cap, thus forming head size. The front band of cap is to be folded



back 3½ inches. Dental hygienists will wear a lilac velvet band, one-half inch wide, and securely basted or tacked to band of cap, one inch from top. Dental assistants will wear the cap without the band.

(D) Dental hygienists may wear a white smock while engaged with a patient. (December 15, 1943.)

6013. UNIFORMS FOR OTHER FACILITY PERSONNEL.—(A) Male hospital attendants, mess attendants, mess stewards, cooks, bakers, meat-cutters, dairy milkers; milk, cream, and butter handlers, and laundry workers will wear, while on duty, white coats and white trousers, and white aprons and caps, as ordered. Male employees assigned to duty in kitchens where heat is excessive will wear neckerchiefs with the V-type neck coats. During the period from May 1 to September 15 or for any part thereof, or for a longer seasonal period, or throughout the year, as ordered by managers, white shirts with black ties may be worn, instead of white coats, by the attendants specified and mess stewards, while the other employees specified herein may wear white shirts without black tie. The tie may be bow or four-in-hand, the belt may be black or white, and the shoes (rubber-heeled for attendants) may be black or white. The type of tie and color of belt and shoes to be worn will be ordered by the manager.

(B) Females occupying any of the positions named in (A), and maids will wear white smocks, aprons if thought necessary, and white caps or head bands; provided that female mess attendants [and female hospital attendants] may wear self-supplied uniforms made to these specifications: Material, white muslin or other low-priced fabric; to be buttoned to hemline to facilitate laundering; short sleeves with turned-back cuffs; lapel type collar; either one or two patch pockets; style, plain princess, preferably without belt. Uniform to be plain cut, without pleats.

(C) Mess attendants and [other] employees handling hot dishes from dish-washing machines will wear white fabric gloves.

(D) Hospital attendants on outdoor occupational therapy assignments may, as required, wear khaki in lieu of white trousers.

(E) Physicians, dentists, dental hygienists and barbers will wear white smocks while [engaged with patients. Smocks will also be worn by pharmacists and laboratorians (including technicians, male and female), or in lieu of smocks, these employees may wear aprons, as issued to cooks. Such aprons, or smocks or operating gowns will also be worn by dental mechanics. Personnel engaged in autopsies will wear cloth aprons or rubber aprons, or both.]

(F) [Housekeepers may wear self-supplied uniforms of material and make specified in (G) for female nursing assistants.

(G) Female nursing assistants will wear self-supplied uniforms made to these specifications: Material of white muslin or other low-priced fabric; to be buttoned to hemline to facilitate laundering; short sleeves with turned-back cuffs, lapel-type collar, either one or two patch pockets; style, plain princess, preferably without belt. Uniform to be plain cut, without pleats. A white head band will be worn with the uniform.

(H) Male nursing assistants will wear self-supplied white trousers and black tie.]

(I) [Male elevator operators] will wear the white coats and trousers, and self-supplied tie, belt and shoes, as provided in (A) for attendants, except as to chevrons and stars. [Female elevator operators will wear white coats and white skirts.]



(J) Ambulance drivers [ ] will wear white coats, as provided for attendants except as to chevrons and stars.

[(K) The operating gowns, white trousers, gauze masks, and white caps supplied to personnel of main operating rooms may also be supplied physicians and nurses in clinics for wearing during operations requiring aseptic technique, and to personnel handling patients with communicable disease.]

[(L)] White suits will be worn, while on duty, by domiciliary attendants, and may be worn by company commanders and company sergeants. The white suits worn by company commanders will have two black bars on each shoulder; the company sergeants will wear a black chevron on the left sleeve of their white coats. Instead of coats, white shirts with black ties may be worn by these persons, as provided in subparagraph (A); but the shirts when so worn by company commanders and company sergeants will bear the insignia prescribed for the white coats. Aprons may be issued to and laundered for domiciliary attendants.

[(M)(1)] Hospital attendants - Head attendants will wear three and attendants (A) two black chevrons (twill tape) upon the sleeves of white coats. Attendants (B) will wear no chevrons.

(2) Mess attendants - Mess attendants (A), head waiters and [assistant] cooks will wear three, and attendants (B) two stripes, of black, upon sleeves of white coats. (3) A star, same color, will be added upon the sleeves of groups (1) and (2), for each five years of service. (4) Patients assigned to dietetic activities as an occupational therapy project will wear [a blue band upon the coat sleeve. The insignia prescribed for coat sleeves may be worn on personally-owned shirts, provided that upon separation of the wearer from the service of the Veterans Administration the insignia will be delivered by him to the supply officer. Female hospital and mess attendants wearing smocks, these insignia will be affixed just above the band on the smock sleeve]. (December 15, 1943.)

6014. FURNISHING AND LAUNDERING OF WHITE SUITS, SMOCKS, ETC.--(A) Except when specified as to be "self-supplied," the washable white coats, white trousers, khaki trousers, smocks, aprons, caps, headbands, neckerchiefs, gloves, and operating gowns prescribed under R. & P. 6013 will be supplied at Government expense. Underwear, shirts, ties, belts, socks and shoes will be self-supplied. All Government issues of clothing will be subject to strict accountability in accordance with governing provisions of Regulations and Procedure, Supply Service. None of such clothing will be worn by employees off duty, and those not quartered on reservations of field stations will be required to change to their personally-owned clothing before leaving upon completion of work hours.

(B) Hospital, mess and domiciliary attendants may be supplied not to exceed [six] white coats and six white trousers as an initial supply. For attendants assigned to patients engaged in outdoor occupational therapy, this initial supply of six trousers may be proportioned between white for indoor wear and khaki (twill, tan color, summer weight) for outdoor detail; thus, the initial supply of trousers to such employees may be three each of white and khaki or four khaki and two white, or other relative proportions judged appropriate. The initial issue of smocks will be [six]; and of white fabric gloves, three pairs. Aprons for kitchen personnel, laboratorians, pharmacists, dental mechanics and personnel engaged in autopsies will be from general laundered stock, and not individually issued. The issue of rubber aprons for autopsy room personnel will be made to the pathologist' (one such apron - to



be worn instead of or beneath the cloth apron, as preferred - for each employee of the autopsy personnel). Coats, trousers, smocks, etc., issued to employees as provided, may be repaired if practicable, or replaced (upon surrender of non-usable article), at Government expense, if rendered unserviceable through normal wear and tear, or if lost or damaged other than through negligence of the employee.

(C) Laundering.--The provisions of R. & P. 9292 (H), which stipulate that personal laundering will not be furnished employees except at stations where commercial laundry service is not obtainable, do not prohibit the use of a station laundry for the laundering, at Government expense, of those articles of washable clothing which employees are required to wear and have soiled during performance of duty. Accordingly, the white coats, white or khaki trousers, smocks, aprons, caps, neckerchiefs, gloves and head bands which have been supplied to individual employees, as provided, may be laundered in the station laundry, in the maximum weekly amounts hereinafter specified. Similarly, may be laundered articles which, though personally-owned by employees were worn as prescribed and were soiled in performance of duty.

(D) Hosiery, underwear and collars will not be laundered at Government expense, nor will shirts worn by officers as specified in R. & P. 6005. Not more than six white shirts that had been worn in lieu of white coats; not more than six white coats that had been worn in lieu of white shirts; and not more than six smocks will be laundered weekly for individual employees who had worn those articles while on duty. White coats and white shirts will not be simultaneously laundered. Four pairs of fabric gloves may be laundered weekly for individual employees who had been ordered to wear them. Laundering will not include dry cleaning. (December 15, 1943.)

【6015. Male nurses will wear self-supplied white, washable coat and trousers, white shirt, black socks, black shoes and black bow tie. The coat and trousers will be of sanforized 8-ounce double-filled duck. The coat will be single-breasted with a lapel collar, 3 detachable pearl buttons and rounded front cut; it will have 1 breast pocket and 2 side pockets, without flap, and not patch type.】 (March 13, 1944.)







## PROCEDURE IN ADMISSIONS TO FACILITIES

PERSONS FOR WHOM HOSPITAL OBSERVATION WITH PHYSICAL EXAMINATION IS AUTHORIZED--  
See R. & P. R-6045; PERSONS FOR WHOM HOSPITAL TREATMENT OR DOMICILIARY CARE  
IS AUTHORIZED - SEE R. & P. R-6046; ELIGIBILITY OF EX-MEMBERS OF THE ARMED FORCES  
FOR HOSPITAL TREATMENT OR DOMICILIARY CARE - SEE R. & P. R-6047-6048.

### ADMISSION FOR OBSERVATION AND PHYSICAL EXAMINATION.

6017. (A) Claimants or Beneficiaries of the Veterans Administration - These may be authorized admission to hospitals or diagnostic centers, for observation and physical (including mental) examination, by chief medical officers, clinical directors, or physicians designated by them, under the following conditions:

(1) When so instructed by the medical director, following upon receipt by him of requests for such service made by the solicitor, the chairman, board of veterans appeals, the director of insurance, the director of veterans claims service, or the director, dependents claims service. Direct requests from those central office officials may also be honored.

(2) Upon receipt of requests emanating from adjudication officers, or (in guardianship cases) from chief attorneys.

(3) Upon receipt of requests from United States attorneys, to establish the present condition of plaintiffs in Government insurance suits.

(4) Upon their own initiative, when they decide that out-patient examination cannot sufficiently develop the identity or physical findings of an examinee's condition. (See Physical Examinations; also Temporary Hospitalization.)

(5) Upon recommendation of chief medical officers or clinical directors, managers may authorize transfer to a diagnostic center of hospitalized patients presenting a diagnostic problem that cannot be solved by the clinical and laboratory facilities available at the hospital. Advice as to appropriate therapy can also thus be sought in appropriate cases.

(6) Diagnostic centers will not be used when the requisite information can be developed by observation and examination in the nearest suitable hospital under the direct and exclusive jurisdiction of the Veterans Administration. (See Proper Use of Diagnostic Centers.) Prior consent of the medical director to proposed use of a diagnostic center is not required.

(7) Form 2557, Admission Card, will be used for authorizing admission to a facility or diagnostic center for observation and physical examination.

(B) Other than Claimants or Beneficiaries of the Veterans Administration.--  
[(1) Hospital observation and examination of Canadian or British Imperial pensioners will be effected if requested or if judged necessary to complete an out-patient physical examination. (2) Employees of the Veterans Administration may be hospitalized, upon request of the manager concerned, to determine whether they are physically or mentally fit to carry on their official duties. (3) The hospitalization of persons referred by other Federal agencies for physical examination will, in the interests of economy, not be effected unless requested or necessary to develop desired data that cannot be completed in out-patient examination.

No charge for examination and observation will be made the employee who is hospitalized under (2) upon authority of the manager. For Canadian or British Imperial pensioners or for examinees of other Federal agencies who had to be hospitalized



for completion of an out-patient examination, the charges will include fifty percent of the fee authorized in the Schedule of Fees, Veterans Administration, for the item or items of the examination, plus \$1.00 for lodging and fifty cents for each meal (or one dollar for a ration). Report will be made to the director of finance on Form 1086, for billing.

Physical examination of two classes of claimants of the United States Civil Service Commission, that is, employees being considered for disability retirement, and annuitants being reexamined to determine propriety of continuing their retirement benefits will probably require hospitalization. Requests for observation and examination of such claimants are signed by the medical director of that Commission.

(C) A change of status from observation and examination to treatment will be reflected by submittal of a supplemental Form 2593. Opposite "Disposition" on that form will be entered "Change from observation to treatment," with date of such disposition. Form P-10 will also be executed and eligibility for the hospital treatment established. Form 404 will be prepared and distributed according to existing instructions.] (February 29, 1944.)

FOR TRAVEL EXPENSES IN HOSPITALIZATION FOR OBSERVATION, SEE PROCEDURE IN TRANSPORTATION.

#### ADMISSIONS FOR HOSPITAL TREATMENT - PERSONS OTHER THAN THOSE ENTITLED AS EX-MEMBERS OF THE ARMED FORCES.

6018. Persons in Active Service with the United States Navy, Marine Corps, or [Coast Guard].--(A) Admission [for hospital treatment by the Veterans Administration of officers or enlisted men of the Navy, Marine Corps or Coast Guard], on active duty, under authority of Public No. 675, 70th Congress, January 19, 1929, will be effected upon requests from the medical director, [Veterans Administration], or from the immediate commanding officer of the applicant. It will be required that such requests incorporate data as to the disease or injury, the name and address of the next of kin, and instructions as to disposition of the patient upon discharge from hospital. If the immediate commanding officer makes request for such hospitalization [upon] the manager of a facility not adapted to treatment of the applicant's condition, [the] request will be forwarded to the manager of the nearest suitable facility, and the commanding officer will be so notified. When a bed is available, the upper part of Form 2557, [Admission Card], will be transmitted to the immediate commanding officer, to be given the applicant or his attendant for exhibition at the receiving facility.

(B) Officers or enlisted men of the Navy or Marine Corps who become ill or injured while absent on liberty or permitted leave, may be furnished hospital treatment by the Veterans Administration, provided that the applicant's condition be "medically emergent to the extent that naval medical facilities are not reasonably available," and that the applicant has not been "more than thirty days absent from his ship or shore station." [Applicants in these circumstances will be authorized hospital treatment by the Chief, Bureau of Medicine and Surgery, Navy Department, Washington, D. C. In an emergency, such applicant may be hospitalized and provided emergency treatment without exhibition of such authorization, but a telegram or radiogram will promptly be sent to the said chief, in which will be incorporated the full name, rank and organization of the applicant, and the ship or shore station to which he was attached. When a reply is received from the Chief, Bureau of Medicine and Sur-



gery, a copy of it will be mailed to the commanding officer of the applicant's naval unit.

Officers or enlisted men of the Coast Guard who become ill or injured while on permitted leave may be hospitalized by the Veterans Administration in accordance with the foregoing procedure as applied to personnel of the Navy or Marine Corps, except that authorizations for such treatment will be obtained from the Commandant, United States Coast Guard, Washington, D. C.]

(C) When the death of a Navy patient in a Veterans Administration facility is anticipated, the manager will promptly notify the next of kin (as communicated by the Navy) by letter, radiogram or telegram as the circumstances demand. When death occurs, the next of kin will be so notified by telegram and instructed to telegraph the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., advising as to the desired disposition of the body. At the same time a priority radiogram or telegram will be sent to the said Bureau of Medicine and Surgery, Navy Department, by the manager, advising of the death, giving full name, rank or rating of the deceased; the name and address of the next of kin; whether the next of kin have been notified and instructed to advise the Bureau as to desired disposition of the body; and requesting instructions accordingly from the said Bureau. Pending receipt of those instructions, the body will be prepared, embalmed and encased under the terms of the burial contract of the facility, and voucher for such service will be transmitted by the manager to the Bureau of Medicine and Surgery, Navy Department, for settlement.

[The foregoing instructions will apply to members of the Marine Corps who die while receiving treatment by the Veterans Administration. When a member of the Coast Guard dies in like circumstances, the procedure will be as provided for deceased Navy patients, except that telegrams or radiograms will be addressed to the Commandant, United States Coast Guard, Washington D. C., to whom also vouchers will be submitted.]

(D) For hospital treatment of [Navy, Marine Corps or Coast Guard patients, the reciprocal Federal hospital per diem rate of \$4.25, effective July 1, 1943, will be assessed. That rate will cover medical and surgical services such as are supplied ex-members of the armed forces, including expensive medicines, blood or plasma transfusions; and cost of telegrams or telephone messages sent in the critical illness or death of such patients, and in requesting authorization for emergency hospital admission. But orthopedic appliances (artificial limbs, braces, eyeglasses, shoes, audition devices, etc.) of a permanent type, for wear after dehospitalization, will not be supplied. Dental services will consist of relief of pain, including extraction or ordinary fillings. If the services of a fee basis specialist have to be procured, the cost thereof to the Veterans Administration will be added to the billing based upon the \$4.25 per diem rate which will be reported to the director of finance on Form 1086. These patients will not be entitled to personal clothing, toilet articles, barbering or tobacco, at the expense of the Veterans Administration. Expense of their travel to and from a facility will not be borne by the Veterans Administration. If ambulance transportation be authorized by the officer requesting the hospitalization, the receiving facility of the Veterans Administration may use the station ambulance or a contract ambulance to bring the patient in; and charge therefor will be made on the Form 1086 that is sent to the director of finance.]

Such ambulance service will be limited to transportation between the nearest



available common carrier passenger station and the facility except in such cases of extreme illness or urgency that ambulance service must be furnished for greater distances. In all such urgent cases, the reasons for using the ambulance beyond the limit of the nearest common carrier service will be furnished in writing by competent medical authority.]

(E) Charges for these in-patients will be reported to finance service, central office, on Form 1086, Statement for Services Rendered Departments or Establishments, for billing [ ]. Separate reports will be prepared, in quadruplicate, for each such patient supplied hospital treatment during any month, within ten days after the end of the month. The original will be signed by the manager, acting manager, or other employee designated by the manager. The third carbon copy will be retained for station files. The original and other two copies will be forwarded through the finance officer of the station, and will be accompanied by the authorization for the service. [ ] (February 29, 1944.)

6019. Persons in Active Service with the United States Army.--(A) [Officers, Army nurses, Women's Army Corps, other militarized female personnel of the Army, contract surgeons (full time), warrant officers, cadets and enlisted men, when in active service, may, under authority of Public Nos. 177 and 852, 76th Congress, be provided hospital treatment by the Veterans Administration.

(B) By Circular No. 387, War Department, November 28, 1942, responsible officers of Army posts, camps and stations (including officers of the Women's Army Corps) and commanding officers of troop trains can authorize hospitalization by the Veterans Administration of personnel named in (A) who become ill or injured while in active duty. The letter of authority will show the name, grade, organization and Army serial number of the soldier; his proper post, camp or station; the nature of treatment desired, with diagnosis, if known, the reason Army facilities are not available; the name and address of the person to be notified in emergency or death; and the point to which the patient is to be discharged or the person to whom to apply for that information.

(C) (1) Air Corps students in training at universities have the status of enlisted men of the Army air forces, and are entitled to hospitalization by the Veterans Administration, when duly authorized. (2) Reserve officers in training schools may be supplied hospitalization, when referred with authorization from a responsible officer, as provided in (B). A contract surgeon (full time) can issue such authorizations, but a civilian physician is not so empowered. (3) Dependents of members of the armed forces can be provided hospital treatment only in an emergency and when other medical attention is not feasibly available. For hospitalization so rendered, charges will be made as provided in R. & P. 6027.

(D) Medical services are not authorized for inducted registrants who are transferred to the enlisted Reserve Corps and returned to their homes to arrange personal affairs. Such enlisted men, when released from active service after induction and transferred to the enlisted Reserve Corps, revert to civilian status and so remain until they are recalled to active service. (Circular No. 362, War Department, November 2, 1942.)]

(E) [Personnel named in (A)] who become ill or injured while absent from their military units on official assignments, or on authorized leave of absence, [pass, furlough] or absence without leave, may be provided hospitalization. In emergency, those applicants may be admitted without the formal authorization specified in (B); but as soon as possible the covering request will be procured from their responsible



superior, who will be informed as to the full name, rank and organization of the patient, [as stated by him, and of the circumstances of his hospital admission. The request coming in reply from the responsible Army officer will give the patient's status, character of absence, and the period of authorized or unauthorized absence.] Deserters (as distinguished from [persons] absent without leave) are not entitled to medical treatment, under a ruling of the Comptroller General (B-20867, November 8, 1941).

[(F)] The hospital service to be rendered these Army patients will be as specified in R. & P. 6018 (D) for [Navy] patients; and the charges (including any telegrams) and reporting thereof to the finance service, central office, will be as provided in R. & P. 6018 [(D) and] (E), except that these will be identified as Army patients.

[(G) Upon the death of an Army patient during such hospitalization, the following procedure will be observed.

1. If there is an Army installation in the vicinity of a Veterans Administration facility, and that installation has a burial contract, the manager of the facility will be so informed. Upon the death of a member of the Army, in active service, at such facility, the manager thereof will telegraph or telephone the authorities of such installation, and request the taking over, preparation and disposition of the body under the said contract. At the same time, the said manager, who will have the name and address of the person to be notified in emergency, will telegraph or telephone such addressee, requesting instructions as to where the body is to be shipped. Meanwhile, the Army authorities will proceed with preparation of the body; and, when informed by the manager (by telegraph or telephone) where the body is to be shipped, will arrange its transportation thereto, and will handle all other matters pertaining to disposition of the body.

2. If there is no Army installation in the vicinity of a Veterans Administration facility in which such death occurs, the manager of the facility will prepare the body under the terms of his burial contract; will telegraph or telephone the emergency addressee as provided in (1); and will ship the body to the point desired, subject to reimbursement by the War Department for all expenses incurred in such preparation and transportation, and including cost of any telegrams or telephone calls made incidental to the procedure.]

[(H)] Form 2557, Admission Card, will be used in hospitalizing these patients. The upper part will be sent to the Army official who requested the service, to be presented by the patient when he arrives at the hospital, in ordinary admissions.

[(I) Transportation incident to hospitalization of these patients will not be provided by the Veterans Administration. If ambulance transportation be authorized by the Army officer requesting the hospitalization, the receiving facility of the Veterans Administration may use the station ambulance or a contract ambulance to bring the patient in; and charge therefor will be made on the Form 1086 that is sent to the director of finance.

Such ambulance service will be limited to transportation between the nearest available common carrier passenger station and the facility except in such cases of extreme illness or urgency that ambulance service must be furnished for greater distances. In all such urgent cases, the reasons for using the ambulance beyond the limit of the nearest common carrier service will be furnished in writing by competent medical authority.] (February 29, 1944.)



6020. [Beneficiaries of the United States Public Health Service.--(A) (1) Whenever and wherever a suitable bed is available, managers of Veterans Administration facilities may admit beneficiaries of the United States Public Health Service, upon requests of responsible officers thereof. Allocation of part or whole of a ward will require prior consent of the medical director.] Public Health Service Form 1971F, containing informative data, including name and address of next of kin, will be supplied by the officer in charge of the hospital of the Public Health Service from which the patient is being so transferred. That form, as the authorization instrument, will accompany the report, Form 1086, which will be prepared and submitted as provided in R. & P. 6018 (E), except for identification of these as "United States Public Health Service" patients. The per diem rate will be [\$4.25] and the services will be as specified in R. & P. 6018 (D).

(B) Should the condition of such patient become critical, a telegram will be sent the nearest of kin. In death of such patient, the same addressee will be informed and asked to instruct as to disposition of the body. The telegram will state that all costs incidental to the preparation of the body for shipment and its shipment will be at the expense of the nearest relative. Prompt reply will be asked. If the addressee refuses these terms, the Medical Officer of the United States Public Health Service will be so informed, and the body will be turned over to the station undertaker [ ] to be interred locally at a cost not to exceed \$100. Vouchers for such expense will be forwarded to the Surgeon General, United States Public Health Service.

(C) The completed Form 2593, Record of Hospitalization or Domiciliary Care, showing discharge or death of such patient, together with a copy of his clinical records, will be sent to the medical officer in charge of the United States Public Health Service station who referred him for hospitalization [ ].

[Travel of these patients to and from hospital will not be at expense of the Veterans Administration.] (February 29, 1944.)

6021. ENROLLEES OF, AND OFFICERS AND MEN ATTACHED TO THE CIVILIAN CONSERVATION CORPS.--[Funds to cover cost of medical treatment of former enrollees and officers and men attached to the Civilian Conservation Corps were not available to the War Department after June 30, 1943. But Title III, Public No. 135, 78th Congress, provided that upon certification by the Director, Civilian Conservation Corps, the United States Employees' Compensation Commission could furnish medical services, including hospitalization and burial, for such former enrollees who were receiving hospital treatment at Government expense on June 30, 1943, and who are not entitled thereto under the act of September 7, 1916 (the United States Employees' Compensation Act) as amended and extended.] (February 29, 1944.)

6022. UNITED STATES EMPLOYEES' COMPENSATION COMMISSION.--(A) [As patients of this Commission, the Veterans Administration will be concerned with (1) beneficiaries whose treatment has been authorized by the Commission; (2) employees of other Federal agencies referred for treatment by the Veterans Administration, as potential beneficiaries of the Commission; and (3) employees of the Veterans Administration, as potential beneficiaries of the Commission.]

The claims of persons in Group (1) will have been adjudicated and treatment (hospital or out-patient) will be proceeded with.

Whether the patients in Group (2) are eligible for treatment as potential beneficiaries of the Commission will have been determined by the referring Federal agency,



which will also have executed and submitted the claim forms to the Commission. The presentation, in duplicate, of Forms CA-16 or CA-17 will be authority for the Veterans Administration to proceed with treatment of such referred patients. The chief medical officer, clinical director, or physician designated by either, in the field station contacted, will retain the original of either such form (for attachment to Form 1086 that is later submitted to the director of finance), and will mail the duplicate direct to the Commission, 285 Madison Avenue, New York City.

(B) For patients in Group (3), employees of the Veterans Administration, who are injured on the premises of the Veterans Administration, necessary treatment may be given as potential beneficiaries of the Commission by executing Form CA-16 and forwarding a signed copy immediately to the Commission. In a case where, although the injury occurred on the station premises, there is a doubt regarding the employee's right to treatment under the provisions of the Employees' Compensation Act because the injury occurred at a time not within the employee's regular tour of duty or for some other reason, Form CA-17 will be executed to request treatment instead of CA-16 and the signed copy to the Commission will be accompanied by a complete statement of the circumstances surrounding the injury. The Commission will advise later whether medical treatment beyond that rendered as an interim measure is authorized after the proper administrative forms have been submitted by supervisory officials to the Commission, either direct or through the director of personnel, as applicable.

(C) Pending adjudication of a claim, the Commission will honor billing from the Veterans Administration for treatment rendered the claimant up to the date of disallowance; and up to and after the date of allowance for any continuance of treatment necessary in the allowed case. Stations, accordingly, will submit monthly reports on Form 1086 to the director of finance, covering treatment up to date of disallowance, or up to completion of treatment in the allowed case. Notice of disallowance will be sent by the Commission to the manager concerned, and, for any treatment on and after that date which is rendered, the patient will be billed, in accordance with the terms of R. & P. 6027 (B); provided that if such employee be potentially eligible for hospital treatment as an ex-member of the armed forces and, from an executed application, Form P-10, he is determined entitled thereto, he may thereafter be carried, without charge, and reported as a beneficiary of the Veterans Administration.

(D) A per diem rate of \$4.25 will be charged for hospital treatment of potential beneficiaries or beneficiaries of the Employees' Compensation Commission. The services furnished at that rate will be those stipulated under R. & P. 6018 (D), for Navy patients. Orthopedic or prosthetic appliances of a permanent type, and dental prosthesis, if required to repair trauma of the jaws, can be supplied at the expense of the Commission in allowed cases.

(E) Surgical operations, other than those necessitated in an emergency, will not be done without procuring approval of the Commission. When a patient has a bilateral hernia, but the disability from only one hernia has been allowed by the Commission, surgical repair will be made only of the hernia allowed. If such patient be an ex-member of the armed forces and, as such, be found eligible for hospitalization, repair of the other hernia may subsequently be made upon his later readmission as a beneficiary of the Veterans Administration.]

(F) Charges for all services or supplies, such as orthopedic appliances and burial services, procured from sources outside the Veterans Administration on authorization of the United States Employees' Compensation Commission will be vouchered on



the Commission's Form S-69, Public Voucher for Services and Supplies of Hospitals and Physicians, in duplicate. These will be supported by a copy of the authorization of the Commission for the service, as well as by copies of the Veterans Administration purchase orders or other authorizations issued to the payee. Each voucher will carry a statement showing the date on which the medical report on Form CA-20 was forwarded to the Commission, and will be completed in the appropriate block (when procurement of orthopedic appliances is involved) by the beneficiary. The authorizing officer will place certifications on these vouchers, showing that services have been rendered or supplies furnished in accordance with contract, or as ordered when not procured under contract. It will also be necessary that a certificate of the payee, showing that articles furnished have been manufactured from materials mined or otherwise procured in the United States, be placed on the voucher. Form 2504, Decision of Questions of Fact and Law, will not be attached to these vouchers. The vouchers will be forwarded to finance service, central office, for transmittal to the United States Employees' Compensation Commission for consideration as to payment.

(G) [Charges for hospital treatment will be reported to finance service, central office, on Form 1086, for billing against the Commission. Separate reports will be prepared in quadruplicate for each patient furnished hospitalization in any month, within ten days after its end. The date upon which the medical report (Form CA-20) was forwarded to the Commission will be shown on these reports. The original report of charges will be signed by the manager, acting manager or other employee designated by the manager. The third carbon copy will be kept at the station. The original and two other carbon copies will be forwarded to the finance service, central office, through the finance officer. These reports will be accompanied by Forms CA-16 or CA-17 or equivalent for transmittal to the Commission with the billing; except that when the request for treatment had previously been furnished, a statement, on Form 1086, of the date that the request form had been submitted to the Commission will suffice. The actual cost of any item of burial or burial service (e.g., embalming) supplied by the station from stock or through utilization of employee labor will be reported to central office separately from reports of other charges.

Forms of the United States Employees' Compensation Commission and their submittal - See R. & P. 9408-9421.] (February 29, 1944.)

[6023 canceled February 29, 1944.]

[6024 canceled February 29, 1944.]

6025. OTHER FEDERAL AGENCIES.--(A) Requests from the Department of Justice to furnish medical services to interned aliens and employees of detention camps [will be honored. If hospital treatment be needed for such persons it may be supplied, beds being available, under the terms of R. & P. 6018 (D). If interfacility transfer of an interned alien is indicated to procure special services not available at the facility of admission, it must first be established, by inquiry upon the commanding officer of the service command in whose territory is located the Veterans Administration facility to which transfer is proposed, whether it is in a military area of a defense command, from which the alien must be excluded. The agent of the Department of Justice in charge of the local detention camp must also consent to the proposed transfer of such alien. All transportation and incidental expenses for such transfer will be defrayed by the Department of Justice.



(B) Medical services as in (A) may be supplied persons interned in war relocation centers not under the jurisdiction of the Department of Justice, but of the War Department, provided written authorization for such service is furnished by a responsible official of such center. Hospital treatment may be supplied, if beds are available, subject to the terms of R. & P. 6018 (D).]

(C) (1) Preparatory measures for cooperation with medical units in the event of civilian casualties from air raids, etc., are to be coordinated through the medical director. Such temporary hospitalization of civilians so injured as may be provided [will be subject to the terms of R. & P. 6018 (D). No dental prosthesis will be furnished unless required for trauma of jaws. Reports of such hospital treatment will be made on Form 1086 to the director of finance, for billing upon the Surgeon General, United States Public Health Service. They will bear certification that the injured civilian was entitled to the treatment under Presidential Order of February 6, 1942. Forms and instructions for such certification are to be supplied by the United States Public Health Service.

(2) Civilian employees of the United States who become injured while engaged in civilian defense training as members of organized units established in accordance with the Air Raid Protection Code issued by the Federal Works Agency, are entitled to benefits under the United States Employees' Compensation Act, as amended. But employees injured while engaged in such activities as members of an organized unit established under the office of civilian defense are not entitled to such benefits.] (February 29, 1944.)

6026. [ ] BENEFICIARIES OF ALLIED GOVERNMENTS.--Besides the medical services authorized for Canadian and British Imperial pensioners, [first World War], under the provisions of R. & P. 7500-7594, hospital treatment, if determined necessary, may be supplied these additional types of beneficiaries of the Department of Pensions and National Health, Canada: (A) American citizens who, discharged from the Canadian forces, have returned to the United States; or who, though not so discharged, are in the United States on furlough; (B) Canadian soldiers on official duty in the United States; (C) Canadian soldiers who become ill or injured while on permitted leave in the United States. These special types of Canadian beneficiaries will be handled in general under the procedure applicable to pensioners, in R. & P. 7500-7594. Since the regional offices, including those which are a part of a facility, will not likely have records showing previous treatment of these applicants, authorization to provide hospital treatment, if needed, for them will be asked of the Department of Pensions and National Health, Ottawa, Canada. The full name and rank and organization of the applicant and general nature of his condition will be communicated in making such requests. A telegraph night letter can be sent collect, if thought necessary. Pending receipt of the authorization, the applicant, if his condition be emergent, may be hospitalized. The hospital admission will be reported to Ottawa by telegraph night letter, collect. A like notice will be sent upon hospital discharge. The per diem rate will be [\$4.25] for such patients. Other than emergency dental services will not be performed, except upon special authorization therefor. No personal clothing, toilet articles, tobacco, etc., will be supplied these hospitalized patients. Stump socks or orthopedic appliances, including shoes, fabricated in workshops of the Veterans Administration can be supplied, subject to charges therefor upon the Department of Pensions and National Health. All transportation issued Canadian beneficiaries, including bridge, ferry, bus and streetcar fares or tokens, will also be charged. For method of reporting such expenses, see finance procedure. See also R. & P. 7500-7594 for other procedural details. (February 29, 1944.)



6027. THE GENERAL PUBLIC IN EMERGENCIES.--(A) For humanitarian reasons, any person who becomes ill or injured in a traffic accident, etc., in the vicinity of a Veterans Administration facility and is brought into that facility, will be given such emergency treatment as is needed, regardless whether such person has no eligibility as an ex-member of the armed forces, or as a beneficiary of some other Federal agency. If first aid had already been given elsewhere, and the patient can be taken with safety to a private physician or private hospital, he or his accompanying representative, if any, will be instructed to procure such other attention. The full name and address of the patient and of his accompanying representative will be recorded, with the circumstances of the illness or injury as related by them. If the patient be unconscious, or has to be taken at once to the surgical suite, the person or persons who accompanied him will be detained until all such information has been obtained and recorded. If, upon conclusion of emergency treatment, it appears upon inquiry that the patient is potentially entitled to hospital treatment by the Veterans Administration because of former military or naval service, Form P-10 will be executed and eligibility fully determined. If the requirements of R. & P. R-6047 and R-6048 are fully met, such continued hospitalization as is necessary may be furnished, without charge for the service if the applicant alleges inability to defray the expense of hospitalization. (June 1, 1942.)

(B) A charge of [\$4.25], plus extra service or supplies if any, will be made for each day of hospital treatment that is necessary to cover a medical emergency. That rate will comprehend a bed, meals, laundry, ordinary medication, X-ray examination, surgical operation and dressings, ordinary nursing care, and emergency dental services. Extra services will include cost of blood transfusion, tetanus antitoxin or other expensive sera or drugs, and services of a fee basis attending specialist. No orthopedic appliances of a permanent type will be furnished, nor will personal clothing, toilet articles, tobacco, etc., be supplied. No transportation to and from the facility will be at the expense of the Veterans Administration. Charges will be reported to the finance officer, for collection, on Form 1216, prepared as provided in R. & P. 4797, signed by the chief medical officer or clinical director or designate, and submitted as soon as the emergency treatment is terminated. If it be found necessary to prolong hospitalization for more than seven days, the bills will be submitted at the end of each such seven-day period. (February 29, 1944.)

6028. PERSONS FOUND INELIGIBLE AFTER HOSPITAL ADMISSION.--Persons who, upon an erroneous finding of prima facie evidence of former military or naval service were granted emergency admission for hospital treatment by the Veterans Administration; or persons authorized ordinary hospital admission upon incorrect official data supplied as the basis of eligibility determinations, or upon erroneous interpretation of correct data, will be discharged from hospital immediately upon discovery of their ineligibility, provided their condition permits of such disposition with safety. Charges in the amount and of the character prescribed in R. & P. 6027 (B) will be collected in the manner provided in that paragraph from these persons. (June 1, 1942.)

6029. [EMPLOYEES AND THEIR FAMILIES.--(A) Emergency hospital treatment may be provided employees of field stations of the Veterans Administration (not entitled as ex-members of the armed forces or as potential beneficiaries of the United States Employees' Compensation Commission) and members of their immediate families] residing on the reservation of a Veterans Administration facility, pending the earliest possible discharge of such patients, and their reference, for any continued treatment necessary, to community physicians or hospitals.



(B) If such facility be in an isolated situation, where the services of a private physician or private hospital are not feasibly available, such treatment as must be continued after termination of the emergency period may be provided at the facility.

(C) For charges, billing and collection, see R. & P. 6027 (B). See also medical treatment of employees. (February 29, 1944.)

#### HOSPITAL TREATMENT OR DOMICILIARY CARE FOR EX-MEMBERS OF THE ARMED FORCES

6035. PRIMARY PROCEDURAL CONSIDERATIONS IN FURNISHING HOSPITAL TREATMENT OR DOMICILIARY CARE.—(A) In providing hospital treatment or domiciliary care for applicants potentially entitled thereto by reason of prior military or naval service in the armed forces of the United States, the following procedure is fundamental:

1. Determination whether an applicant is eligible for and in need of hospital treatment because of an injury or disease that had been incurred or aggravated in active military or naval service, under R. & P. R-6047 (A) or (B).

2. Determination whether the applicant is eligible for and in need of hospital treatment or domiciliary care under the governing provisions of R. & P. R-6047 (C), (D), (E) and R-6048.

3. Observance of the specified order of preference to be shown the various classes of applicants, as provided in R. & P. R-6047.

4. Expedition in handling applications, concluding eligibility determinations, and conducting incidental correspondence.

5. Expedition in providing the hospital treatment or domiciliary care that is desired and determined as needed, with understanding of the pivotal responsibility placed upon the manager of the facility that is first contacted, and avoidance of unnecessary references of applications from one station to another. (July 22, 1942.)

6036. FORM OF APPLICATION FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.—(A) This will be made on Form P-10, by the applicant, or his guardian, nearest relative or representative.

(B) All letters, telegrams or telephonic messages requesting hospital treatment or domiciliary care, all executed applications that are returned, and all applicants in person for such benefits, will be routed to an eligibility clerk to be assigned to the medical division (or if there be no position specifically designed as such, then to such other clerk to be assigned to the medical division as the manager may designate) in the facility or regional office contacted. Employees to whom Form 4505 has been issued are empowered to administer the oath and execute the certification on Form P-10. The eligibility clerk will immediately deliver to the chief medical officer or clinical director or designate of either any requests for hospital treatment that allege medical emergency, so that action in R. & P. 6037 (A) may be taken. A close liaison between the eligibility clerk and the chief medical officer, clinical director or their designates is essential in all matters pertaining to establishment of eligibility for hospital treatment or domiciliary care and provision thereof.

(C) In applications for hospital treatment for a disease or injury when the disability from it has been adjudicated as incurred or aggravated in line of duty in active service, that is, under R. & P. R-6047 (A) or (B), the answers to the questions on Form P-10 as to income or ability to defray the expense of the hospital treatment, or of transportation incident to it, or as to coincidental right to hos-



pitalization because of a sickness or accident insurance policy, a group hospitalization plan, benefits from an industrial commission or a fraternal lodge, etc., need not be recorded. Similarly, applicants for hospital treatment under Public No. 18, 76th Congress, that is, retired personnel (not Regular Establishment) who had service only in a period other than wartime and so are not entitled as veterans of a war, are not required to answer the questions as to income or ability to defray expense of hospitalization, or right to hospital treatment through other sources, since these applicants, if accepted, are required to pay the subsistence per diem rate provided for them. They will also be required to supply their own transportation to and from a Veterans Administration facility.

(D) An applicant who, though having a service-connected disability, is requesting and is in need of hospital treatment only for a disease or injury not attributable to military or naval service, will have his eligibility determined under R. & P. R-6047 (C), (D) or (E).

(E) Form P-10 will be retained at the station where eligibility had been determined and hospital admission authorized. When Government facilities other than those under direct and exclusive jurisdiction of the Veterans Administration are used, or State, city or private hospitals, the regional office of the territory will retain the applications. Form P-10 will not accompany a beneficiary who is being transferred for hospital treatment or domiciliary care to another facility; Form 2557, Admission Card, will be the instrument of authorization in interfacility transfers.

(1) Approved Form P-10 will be filed affixed to the inside of the front flap of the facility correspondence files of beneficiaries concerned, together with the list of prospective heirs or Form 1170 (whichever was prepared). Other contents of correspondence files may include any affidavit of inability to defray expense of transportation that had been executed by a beneficiary who, in disciplinary status, had been authorized emergency hospitalization; and the agreement to pay the per diem rate to be assessed against patients granted hospital treatment under Public No. 18, 76th Congress (that is, retired personnel, not Regular Establishment, who had service only in a period other than wartime). The exhibits supportive of the eligibility of the applicant for hospital treatment or domiciliary care, that is, any Form 3101 series, copy of discharge certificate, etc., will be kept, properly identified, in an abeyance file, subject to release, upon Form 3116, request from the chief clerk, to an adjudication agency that is considering a claim for a monetary benefit from the same beneficiary.

(2) Rejected Forms P-10 will be filed in medical files, active or inactive, pertaining to beneficiaries entitled to out-patient treatment. If such files do not exist, these forms will be placed in a manila folder, held for one year, and then recommended for disposition as inactive records. Any exhibits which had been assembled in determining the non-eligibility of rejected applicants for hospital treatment or domiciliary care (such as Forms 3101 series, copy of discharge certificate, etc.,) will be placed in an abeyance file and held subject to release as provided in (E) (1) for like exhibits. (November 19, 1943.)

6037. REQUESTS BY MAIL, TELEGRAM OR TELEPHONE FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.--The procedure in these requests, for hospital treatment, will depend upon whether a medical emergency is alleged or suggested by the conveyed information. This consideration will not attach to such requests for domiciliary care, unless it is apparent that those applicants may have to be given hospital treatment before assignment to domiciliary barracks.



(A) Emergency - (1) If the information indicates necessity for emergency hospitalization, an immediate establishment of prima facie eligibility will be made from such records related to the applicant as may be in possession of the station contacted. These will include his case file (period of service, character of discharge, service connection aspects, etc.); a medical file showing eligibility for outpatient treatment, or perhaps containing a rejected Form P-10 formerly disposed of; a previously approved Form P-10 that might be filed in an inactive correspondence file; or possibly a section 202 (10), World War Veterans Act file, showing application for hospitalization in the past. If any such data be available and they show patent ineligibility, the applicant will be advised accordingly, with a brief explanation. If prima facie eligibility be shown, emergency hospitalization will be arranged by the chief medical officer, clinical director or their designates, in accordance with the special procedure provided therefor, conditional authorization for attendant, ambulance, etc., being stipulated if there is paucity of information as to the actual condition of the applicant. If the station has none such records to establish prima facie eligibility, no delay will be caused by effort to procure such data from any other facility or office, but emergency admission will similarly be arranged. The fact that the applicant is in an uncleared disciplinary status does not prohibit emergency hospitalization, but does forbid the furnishing of transportation and other traveling expense, unless the applicant alleges inability to defray the cost of travel to the facility designated. In such case, he may be provided transportation, but only upon condition that he execute, as soon as possible after his arrival at the facility, an affidavit of inability to defray travel expenses.

(2) A regional office, including one which is a part of a facility, may authorize emergency hospitalization not only in a facility under direct and exclusive jurisdiction of the Veterans Administration, but in another U. S. Government hospital (Army, Navy, Public Health Service) that is allocated to it, or in a civilian contract hospital (if it be sufficiently clear that the applicant's emergency has arisen from a service-connected disease or injury). But a facility under direct and exclusive jurisdiction of the Veterans Administration will be selected for the emergency hospital admission, if it is feasibly available.

(3) A facility without regional office, if directly contacted, will effect the emergency admission. If, upon conclusion of the emergency, there is need for continued treatment the patient may be transferred to a facility more suitable, provided that his eligibility for hospitalization has been definitely established.

(4) The execution of Form P-10, in an emergent hospital admission, may be deferred until after the arrival of the patient, but will not be unnecessarily delayed thereafter. If it be then found that the patient had no actual eligibility for hospitalization, he will be discharged as soon as he can travel with safety, and he will be billed for the cost of hospital treatment, including any expense of transportation incident to it.

(B) No Emergency - (1) If the request for hospital treatment or domiciliary care does not allege nor suggest a medical emergency, prima facie eligibility will be determined as in (A). The most recent Form 2593, Record of Hospitalization or Domiciliary Care, in the case file, will be consulted to note if the applicant is still in an unexpired period of exclusion from hospitalization or domiciliary care because of an offense against facility discipline. If ineligibility be evident from this or from official records of military or naval service, the applicant will be



so informed, with brief explanation. If prima facie eligibility be shown, or the contacted station has no records in its possession upon which to determine such eligibility, the applicant will be mailed a Form P-10, accompanied by a station mimeographed letter instructing as to its execution. Particularly, those instructions will direct full answers to all questions; will point out the necessity of physical examination by the applicant's physician, who is to fill out the medical certificate, page 3; will caution that the completed form be sworn to before a notary public or other officer authorized to administer oaths for general purposes; will direct attention to the penal provisions, page 1, for false or fraudulent statements; and will request that the Form P-10 be returned to the station that mailed it, accompanied by the applicant's discharge or a certified copy or certificate in lieu thereof.

(2) If a regional office purposes to authorize the hospitalization of the applicant in a facility under direct and exclusive jurisdiction of the Veterans Administration; or a facility intends to refer the applicant - because of no bed being available or because it is unsuited to treatment of the applicant's condition - to another facility, it is allowable to instruct him to send the completed Form P-10 to the designated facility, instead of returning it to the station which mailed him the application. This variation in procedure is, however, optional. It should be used only if economy of time can be expected, and it will entail the responsibility that the station so instructing will, without delay, forward directly to the facility selected for the hospitalization all the data that would have been entered on page 4 of the Form P-10 had it been returned to that station; or, in the absence of such data, the information, "Case file believed to be in possession of (facility) (office) at \_\_\_\_\_."]. (July 22, 1942.)

6038. [ACTION WHEN COMPLETED FORM P-10 IS RECEIVED BY MAIL.--If a Form P-10 returned by mail has been incorrectly and incompletely executed, it will be sent back to the applicant, with instructions for correction. If a returned Form P-10 be found satisfactorily executed, the further action taken will be as follows:

(A) At a Regional Office - (1) Should it be purposed to refer the applicant for hospital treatment to the nearest suitable facility under direct and exclusive jurisdiction of the Veterans Administration, the regional office will fill in the answers to Questions 1 - 8, page 4, of the Form P-10, as transcribed from the case file or other data in possession of the office. If no informative data are possessed, the notation "Case file believed to be in possession of (facility) (office) at \_\_\_\_\_, will be entered, page 4, of the application, which will then promptly be forwarded to such selected facility. The applicant will be notified by a mimeographed station form letter that his Form P-10 has been so referred; that at that facility his eligibility will be determined; that a little time is necessary for this; that he must not proceed until he receives authorization from the manager of the facility; but that, if his condition becomes emergent, he is so to notify that manager by telegram or telephone. (2) Should it be intended to authorize admission to some other Government hospital allocated to the regional office, the data, page 4, need not be filled in, since determination of eligibility is to be made at the regional office and the Form P-10 retained there.

(B) At a Regional Office Which is Part of a Facility - If it is intended (1) to refer the applicant to another nearest suitable facility because of lack of a bed or because the facility that received the completed Form P-10 is not suitable for treatment of the condition of the applicant; or (2) if it is purposed to utilize a Govern-



ment hospital allocated to the station, then the provisions of (A) will guide as to disposition of the satisfactory application. If (3) it is planned to admit the applicant to the facility itself, then determination of eligibility will be proceeded with, as provided in R. & P. 6041.

(C) At a Facility with no Regional Office - The action will be as in (B) (1) or (3). If action under (B) (1) be taken, the applicant will be advised of the reference of his application, as provided in (A) (1). (July 22, 1942.)

6039. REQUESTS IN PERSON FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.--(A) If an applicant for hospital treatment or domiciliary care who presents himself in person at a field station is found in need of emergency admission, it will be authorized, after prima facie eligibility is determined, in the manner provided in R. & P. 6037 (A). Preparation of Form P-10 should be made before such hospitalization, but may be postponed until after it.

(B) (1) If his condition does not require emergency hospitalization, prima facie eligibility will be determined as before, including ascertainment of disciplinary status from the latest Form 2593 in the case file. If he be found patently ineligible, he will be so informed, with a sufficient explanation, and Form P-10 will not be executed. If prima facie eligibility is shown, or if the station contacted is not in possession of data upon which to make that determination, he will be assisted in the preparation of Form P-10, the medical certificate being executed by a physician of the station, and the completed application sworn to, as provided in R. & P. 6036. The succeeding steps will be as follows:

(C) At a Regional Office - (1) Admission to a facility under direct and exclusive jurisdiction of the Veterans Administration will be preferentially authorized. The data on page 4, Form P-10, will be filled in if the case file, etc., be in possession of the office. If not, the applicant's statement as to the station holding his case file will be read, and a notation placed on page 4 of the application, reading: "Case file believed to be in possession of the (office) (facility) at \_\_\_\_\_." The Form P-10, with such additions, will then be forwarded without delay to the nearest suitable facility. The applicant will be informed where this application is to be referred, and instructed to return to his place of residence and not to proceed to the facility designated until he receives authorization from the manager thereof, who will determine his eligibility for the hospital treatment or domiciliary care. (2) If admission to another Government hospital allocated to the regional office be proposed, the data on page 4 of the application need not be entered. Determination of eligibility will be proceeded with as provided in R. & P. 6041.

(D) At a Regional Office which is a Part of a Facility - (1) If, because of lack of a bed or because the facility is not suitable for treatment of the applicant, such station refers the completed Form P-10 to another facility under direct and exclusive jurisdiction of the Veterans Administration, the data on page 4 of the application will be filled in or the prescribed notation in lieu will be entered, and the Form P-10 mailed without delay to the nearest suitable other facility. The applicant will be informed of the reference, as provided in (C) (1). (2) If another Government hospital allocated to such station is to be utilized, or if the admission is to be made to the facility itself, the directions in (C) (2) will be followed.

(E) At a Facility without Regional Office - To obviate the inconvenience caused an applicant who is refused admission upon his personal appearance at a facility, and to economize the cost that would be incurred for transportation from his home to the facility should he later be found eligible, it is desirable, whenever possible,



to admit such applicant if a bed be available. Eligibility, therefore, will be determined as provided in R. & P. 6041 and, if favorable, admission will be authorized. If a bed be not available, he will be informed that his name will be placed on the list of waiting applicants, and he will be later instructed to return for admission if he be found eligible.

(F) When a Form P-10 is prepared on behalf of an applicant in person at any field station, all statements as made by him and recorded will be read to him before his signature (or his mark, if he is illiterate) is affixed and he is sworn. The penalty provisions at the top of page 1, Form P-10, will first be read, slowly and clearly. (July 22, 1942.)

#### 6040. REFERENCE OF APPLICATIONS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.—

(A) To obviate delay in effectuating domiciliary or hospital care and the expense and inconvenience of extended travel, every possible effort must be made to admit an eligible applicant to the facility nearest his location and where his application has been received, particularly in emergencies. If, however, the said facility is not equipped to furnish the required care, the application will be promptly referred to the nearest suitable facility with an available bed, and the applicant will be so notified and instructed to await advice from the facility to which his application was forwarded. The facility receiving a referred application will, without delay, determine eligibility for and need of care, and will advise the applicant of rejection or acceptance, respectively, giving reason for rejection, if made. If the applicant is accepted, all necessary arrangements as to transportation will promptly be effected and transportation and meal and lodging requests, if furnishable, will accompany the notice to him to report. What is enjoined as regards admissions whenever possible to that facility nearest the applicant's location, applies even more forcibly to facilities to which applications are referred from other facilities. More than one reference of an application should be resorted to only under exceptionally justifying circumstances.

(B) Reference will be had to the list of "Allocation of Facilities," (see Bulletin No. 24 series), arranged alphabetically by States. Veterans Administration facilities and regional offices are authorized to utilize the facilities so allocated to them in admitting or referring applicants for domiciliary or hospital care. These allocations will be subject to revision as indicated, either upon initiative of central office or upon convincing representations from field stations.

[(C) See (A) as to acceptance of the applicant at the nearest suitable facility at which he applied, if a bed be available. In medical emergencies, applicants will be accepted at the facility first contacted, whenever at all possible, even if the facility is not primarily of the type indicated. Interfacility transfers of such emergency patients can subsequently be effected, if their condition permits and continuance of treatment is needed. In other than medical emergencies, if the facility to which application was made is not suitable for the required type of treatment or, if suitable, has no bed available, the application will be forwarded at once to that other facility which is suitable and which has an available bed. In no case will a Form P-10 be referred to any of the suitable facilities allocated to the station having the application unless and until it is established that a bed is available. The Form P-10 will be held at the facility in possession of it until the availability of a bed at one of the suitable facilities allocated has been established. If it is ascertained that a bed is not available in any of the suitable facilities allocated the



facility holding the application, the applicant will be so advised and will be further informed that his Form P-10 is being held and his name being placed on the facility's waiting list until such time as a bed is available, whereupon he will be so notified. Facilities which are mutually allocated in Bulletin No. 24 series may arrange a reciprocal report of their unoccupied beds, at such intervals - weekly or twice weekly, etc. - as are judged satisfactory.]

[(D)] The utilization of Government hospitals other than those under the direct and exclusive jurisdiction of the Veterans Administration must be strictly in accordance with authority in R. & P. R-6050 and the allotment of beds in such hospitals (see Bulletin No. 24 series). These other Government hospitals have been allocated, generally, only to the regional offices or facilities with regional office activities in the territories of which these other Government hospitals are located. But, in a few instances, such other Government hospitals (e.g., Fitzsimons General Hospital, Denver, and Naval Hospital, Philadelphia) have also been allocated to regional offices other than the one in whose territory the hospital is located. Since the utilization of a specific number of beds only is allowed in such other Government hospitals, subject to budgetary allotments, it is essential that admissions thereto be controlled. To effectuate this, the regional office of the territory in which any such allocated hospital is located will act as a clearing house; and those regional offices not in the territory of the other Government hospital, but to which it is allocated, will wire or write, as circumstances justify, the manager of the regional office in whose territory the hospital is located, before authorizing admission thereto. The latter manager will be responsible for not exceeding the permitted quota of patients in such hospital. (November 19, 1943.)

#### DETERMINATIONS OF ELIGIBILITY FOR HOSPITAL TREATMENT OR DOMICILIARY CARE

6041. DATA FOR DETERMINATIONS AND THEIR PROCUREMENT.--(A) Eligibility for hospital treatment or domiciliary care will be decided from the applicant's sworn statements on Form P-10, when considered with data related to the period or periods of his military or naval service, character of his discharge or discharges, service connection or lack of service connection for disability from the disease or diseases, injury or injuries he suffers from (particularly as related to the condition for which he presently needs treatment), disciplinary status (as reflected on Form 2593 in a case file), etc.; that is, the data listed on page 4 of Form P-10. Such data are to be procured from records incorporated in the applicant's case file; or in his medical file (active or inactive), if any, used for out-patient service; or in an inactive correspondence file related to him (containing perhaps a formerly disposed-of Form P-10). If such data are not in possession of, and have not been forwarded to the station that is to make the eligibility determination; or if the applicant had not previously filed a claim for a monetary benefit, or hospital or out-patient treatment, or for domiciliary care, then the official records of the Army, Navy, Marine Corps or Coast Guard are to be procured, through central office, in accordance with (C) hereof.

(B) A regional office which has received a completed Form P-10 will, in referring it to a facility under direct and exclusive jurisdiction of the Veterans Administration, fill in the answers to questions 1 - 8 on page 4 of the form, should any



of the data specified in (A) 1 - 4, be in possession of that office; and, if not, will have recorded in lieu the notation informing as to the station that has possession of the case file. The facility receiving the application so referred, will promptly request the designated station having the case file to supply the data, and that request will be honored without delay. A regional office which authorizes admission to another Government or civilian hospital need not complete the data on page 4 of Form P-10, since the Form P-10 in such cases is retained in that regional office. Nor need a facility which is making admission to itself fill in the data on page 4 of Form P-10 aforesaid. (August 1, 1942.)

(C) (1) [When the applicant for hospital treatment or domiciliary care has not previously filed a claim for a benefit (either monetary or treatment or care), or is not simultaneously filing claim for a monetary benefit with application for hospital treatment or domiciliary care, the eligibility clerk will at once execute the appropriate form of the 3101 series, requesting official data, addressed to the chief clerk, attention of records verification unit, central office. A copy of that form will be routed to the mail and records unit, for placing in the abeyance file. When the completed Form 3101 series is returned from central office, it will be checked across the index and abeyance files to determine its proper distribution and whether a Form 526, Application, has been filed in the meantime. Following this check, the completed Form 3101 series will be sent to the eligibility clerk who, after it has served his purpose, will route it to the adjudication officer, if a claim for a monetary benefit has been filed. If claim for compensation or pension is simultaneously filed with application for hospital treatment or domiciliary care, the Form 3101 series will be executed by the adjudication division of a combined facility.] (November 19, 1943.)

(2) When an applicant states on Form P-10 that he has previously filed a claim for monetary benefits, hospital treatment or domiciliary care, and there are not sufficient data at the facility receiving the application, then Form 505 will be forwarded directly to the office which is in possession of the applicant's case-file. If that file be in the facility which received the application, and it contains a form of the 3101 series, but additional information is needed from the service concerned (Army, Navy, Marine Corps, Coast Guard), then the appropriate form of the 3101 series, plainly marked "Supplemental", will be forwarded to the chief clerk, central office, attention record verification unit.

(3) Inasmuch as hospitalization can be authorized in a medical emergency upon establishment of prima facie eligibility only, with execution of Form P-10 and definitive determination of eligibility to follow such admission, there should be little if any necessity for resort to telegrams in requesting central office to procure service data. Ordinary mail, or lettergram at the most, should suffice, with perhaps air mail from trans-Mississippi stations, when urgency is thought indicated. (August 1, 1942.)

6042. PROCEDURE UPON ASSEMBLAGE OF DATA.--(A) The data essential to determination of eligibility for hospital treatment or domiciliary care being assembled, the eligibility clerk will proceed with these considerations: The periods of military or naval service, whether in war time or in peace time or both; length of service, or discharge for disability in line of duty in active service; whether discharge from the most recent period of service was honorable, dishonorable or not dishonorable; which disabilities are service-connected and which are not service-connected; whether, if the applicant had peace-time service only, he had been discharged for disability



in line of duty, or is in receipt of a pension for service-connected disability; whether the applicant has no adequate means of support, or has sworn that he is unable to defray the expenses of hospitalization or domiciliary care, and of the transportation incident thereto; whether there is an uncleared offense against facility discipline. If the applicant fails to meet any of these requirements under R. & P. R-6047 and 6048, the eligibility clerk will so certify, over his signature and will forward the Form P-10 to the manager or his designate, accompanied by a letter for signature, notifying the applicant of his ineligibility, with reason briefly stated. The manager or his designate, if concurring, will sign and issue the letter to the applicant, delete "(Approved)" from the notation at the bottom of page 4 of Form P-10, sign the rejected application, and refer it for filing as provided.

(B) If the applicant meets those requirements, the eligibility clerk will so certify over his signature on the Form P-10 and route it at once to the physician designated to make the medical determinations. These will relate to the identity of disease or injury; whether it requires hospitalization; if so, whether emergency or extensive treatment is needed; and whether, if domiciliary care is applied for, the applicant has a disability of the type and degree that indicates need for domiciliation. The definitions in R. & P R-6048 of "Permanent disability," "Other conditions requiring emergency or extensive hospital treatment," and "Any disability, disease or defect" will guide in these medical determinations. If the applicant does not meet these, the physician will so certify on the Form P-10, and will sign and forward the rejected application to the manager or his designate, with a letter notifying the applicant of his ineligibility, and an added brief statement of the reason therefor. The manager or his designate, if concurring, will sign and issue the prepared letter to the applicant, certify disapproval, sign and refer the rejected application for filing, as provided.

(C) If the medical determinations are favorable, the physician will so certify, sign, and refer the Form P-10 to the manager or his designate, who will, if concurring, certify accordingly and sign the Form P-10, refer it for filing in a correspondence file, and direct issuance of orders to report, with inclosure of transportation and necessary meals and lodging request, if furnishable in the case.

(D) The delegation by the manager of authority to his designate to certify Forms P-10 will not lessen the manager's responsibility to assure himself that all determinations are being properly and promptly made. (August 1, 1942.)

6043. [ACCEPTANCE OF MINIMUM REQUIREMENTS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.--(A) An applicant in an emergent condition, regardless whether that condition be service-connected or not, is to be granted priority in hospital admission. Next in priority will come an applicant needing hospitalization for a service-connected disease or injury. After such requests are met, the remaining hospital beds will be allotted in the order of preference specified in R. & P. R-6047.

(B) When sufficient empty beds are available to meet requests from two or more applicants, who had served in a period of war, for treatment of diseases or injuries not attributable to military or naval service, the minimum requirements represented by the provisions of R. & P. R-6047 (E) may be applied, for expedition in effecting admission. (August 1, 1942.)

6044. [ELIGIBILITY REQUIREMENTS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE PERTAINING TO APPLICANTS DISCHARGED FROM THE ARMED FORCES: (A) Hospital Treatment for a Service-Connected Condition in a Veteran of a War (R. & P. R-6047 (A))--1. Veteran



of a war as defined (see R. & P. R-6047 (A) and R-2694 (A)). 2. Honorable discharge from last period of war service. 3. The treatment to be for a disease or injury adjudicated as attributable to war service. 4. Such treatment to be medically determined as needed. 5. A clear status regarding previous infraction of facility discipline. Active service in the Coast Guard will be considered "Active military or naval service." Consult Administrator's Decision No. 163, August 30, 1933 as to types of discharges, and R. & P. R-1064, same subject.

(B) Hospital Treatment for a Service-Connected Condition Comprehended by Veterans Regulation No. 1 (a) (R. & P. R-6047 (A))-1. Receipt of disability compensation for injury or disease incurred after being drafted and prior to rejection for military service, or after being called into the Federal service as a National Guardsman but before Federal enrollment. 2. Period between April 6, 1917 and November 11, 1918. 3. Injury or disease in line of duty, and not due to misconduct. 4. Treatment to be for service-connected condition. 5. Treatment to be medically determined as needed. 6. A clear disciplinary status.

(C) Hospital Treatment for a Service-Connected Condition Incurred in Other Than War Period (R. & P. R-6047 (B))-1. Honorable discharge for disability incurred in line of duty in active peace-time service; or receipt of a pension for service-connected disability. 2. The treatment to be for a service-connected disease or injury. 3. The treatment to be medically determined as needed. 4. A clear disciplinary status.

If such applicant had had two or more periods of peace-time service, but the discharge from the last of these was not honorable, hospital treatment may be authorized only for a disability incurred in line of duty in a period of service from which he was honorably discharged therefor.

Note R. & P. R-6047 (B)(4) as to medical director's authority to make, upon proper cause shown, a finding of discharge for disability in line of duty, independently of a departmental discharge for expiration of enlistment.

(D) Hospital Treatment for a Condition not Service-Connected, or Domiciliary Care; Veteran of a War (R. & P. R-6047 (C)) -1. Veteran of a war, as defined (see R. & P. R-6047 (A) and R-2694 (A)). 2. Honorable discharge from last period of war service. 3. Service for 90 days or more commencing in or extending into a war period. Constituting continuous service; or discharge for disability in line of duty in active service. 4. To be suffering from a permanent disability, tuberculous or neuropsychiatric ailment, or other condition requiring emergency or extensive hospital treatment. 5. To be incapacitated from earning a living. 6. To have no adequate means of support. 7. Need for hospital treatment or domiciliary care to be medically determined. 8. Disciplinary status to be clear.

See definitions in R. & P. R-6048 as to "Permanent disability," "Such other conditions requiring emergency or extensive hospital treatment," and "No adequate means of support."

(E) Hospital Treatment for a Condition not Service-Connected, or Domiciliary Care; Peace-Time Service Only (R. & P. R-6047 (D))-1. Honorable discharge for disability incurred in line of duty in active peace-time service, or receipt of pension for a service-connected disability. 2. To be suffering from a permanent disability, or tuberculous or neuropsychiatric ailment, or other condition requiring emergency or extensive hospital treatment. 3. To be incapacitated from earning a living. 4. To have no adequate means of support. 5. Need for hospital treatment or domiciliary care to be medically determined. 6. Clear disciplinary status.



The medical director's determination whether a discharge assigned for reason other than disability (e.g., for expiration of enlistment) could be properly held a discharge for disability (see R-6047 (B)(4)) applies to this group.

(F) Hospital Treatment for a Condition Not Service-Connected, or Domiciliary Care; Veteran of a War (R. & P. R-6047 (E)). 1. Veteran of a war, as defined (see R. & P. R-6047 (A) and R-2694 (A)). 2. Discharge not dishonorable (see Administrator's Decision No. 163, August 30, 1933, and R. & P. R-1064 as to types of discharges). 3. Sworn statement of inability to defray expense of the treatment or care and of transportation incident thereto. 4. To be suffering from a disability, disease or defect which, being susceptible of cure or improvement, indicates need for hospital treatment; or which, being essentially chronic in type and not susceptible to improvement or cure by medical treatment, is producing disablement of such probable persistency as will incapacitate from earning a living for a prospective period, and therefore indicates need for domiciliary care. 5. Determinations as to 4 to be medical. 6. Clear disciplinary status. See R. & P. R-6048 for definition of "Any disability, disease or defect," and for "Inability to defray expense," etc.

(G) Upon conclusion of determinations of eligibility for hospital treatment or domiciliary care, there will be returned to the applicant such exhibits as he may have submitted, that is, record of discharge, certified copy or certificate in lieu thereof, etc.; provided that if it is his first application for any benefit - monetary or treatment or care - a copy of any such exhibit will be made at the station concerned and, after certification by the eligibility clerk, that copy will be filed in his Form P-10. (August 1, 1942.)

6045. CERTAIN CONSIDERATIONS IN DETERMINING ELIGIBILITY.--(A)(1) Veteran of a War - The provisions of section 5, Public No. 304, 75th Congress, that "Reenlistment after November 12, 1918, and before July 2, 1921, where there was prior service between April 6, 1917, and November 11, 1918, shall be considered as World War service," have no application to R. & P. R-6047.

(2) A veteran of a war is one who had had military or naval service in the periods defined in R. & P. R-6047 (A) and R-2694 (A). Eligibility for hospital treatment of a service-connected condition in applicants who had been discharged from the armed forces [before] December 7, 1941, (and who had had no previous service in a war period) will be determined under the provisions of R. & P. R-6047 (B); for hospital treatment of a nonservice-connected condition under R. & P. R-6047 (D); and for domiciliary care under R. & P. R-6047 (D).

(3) Members of training camps authorized under section 54, National Defense Act of June 3, 1916, who were enrolled in such camps on or after April 6, 1917, and before November 12, 1918, are held to have been "Veterans of a war." But, besides these persons who attended training camps at various army posts, to obtain a commission upon satisfactory conclusion of such training, there were other persons whose objectives were civilian in character, that is, they attended these camps to qualify as instructors in various colleges. This latter group is not eligible for benefits under R. & P. R-6047 (see Administrator's Decision No. 371, March 26, 1936).

[(4) An applicant who had been transferred to the reserve following active service, is potentially eligible for hospital treatment or domiciliary care upon exhibition of a certificate of such service.] (March 22, 1944.)

(B) Eligibility of cadets and midshipmen discharged from the academies at West Point and Annapolis is defined in R. & P. R-6047 (B).

(C) Paymasters' clerks of the United States Army who served as such in the Spanish-American War, Philippine Insurrection or Boxer Rebellion are potentially en-



titled to hospital treatment or domiciliary care under R. & P. R-6047 and 6048. Contract surgeons who did not serve overseas in the Spanish-American War, etc., are not so entitled.

(D)(1) Applicants who had deserted prior to cessation of hostilities in the World War, irrespective whether they had not been dishonorably discharged, will be rejected for hospital treatment or domiciliary care; provided that, when such applicant had absented himself from his command for a period of permitted leave granted prior to November 11, 1918, and extending beyond the date of cessation of hostilities; and did not return because he did not know it was necessary for him so to do, he will retain potential eligibility for these benefits. Central office opinion will be requested as to entitlement in these circumstances; the request will be accompanied by a full explanation of the facts. (2) The provisions of this subparagraph are also applicable to Spanish-American War veterans.

(E)(1) Discharge from the armed forces in the World War because of alienage will not, per se, exclude an applicant from hospital treatment or domiciliary care under R. & P. R-6047. The determinant will be whether the applicant was discharged upon his request, that is, had asked release because he was an alien. If he had been discharged because of the War Department Order of January 27, 1918, which directed that "All subjects of countries with which we are at war who do not desire to serve in the United States," be released, this would not invalidate his potential entitlement aforesaid. Individual consideration is to be given applications which present these circumstances. There should be affirmative evidence that the applicant had not solicited an alienage discharge. Discharge before November 12, 1918, is presumed to have been at the alien's request, and the burden of proof is upon him to show it was not. The question whether evidence so submitted is sufficient to rebut the presumption that the applicant had been discharged at his own request is one of fact. (2) Request of an alien for discharge, after November 11, 1918, will not debar him from hospital treatment or domiciliary care, if he meets other requirements (see R. & P. R-1001 (J)). (August 1, 1942.)

(F) (1) Persons who, applying for hospital treatment or domiciliary care before March 17, 1943, were rejected because they could not meet the then requirements of a discharge for disability in line of duty or receipt of pension for a service-connected disability, may have become eligible for these benefits because of the provisions of Public No. 10 of March 17, 1943. The file of rejected Forms P-10, maintained in accordance with R. & P. 6036 (E)(2) will show such applicants. Any such person who reapplies for hospital treatment or domiciliary care will be required to file a new Form P-10, as his physical condition and economic status will likely have changed since his original application was submitted.

(2) A Certificate of Service, Form 280, War Department, is acceptable in lieu of a certificate of honorable discharge. That form is issued to reserve officers (including reserve nurses); commissioned officers, warrant officers and enlisted men of the National Guard of the United States; and trainees inducted under the Selective Training and Service Act, who satisfactorily complete the required period of active military service in the United States Army, or who are honorably separated from the military service or honorably relieved from active Federal service prior to completion of the required period of service. A certificate of service denotes transfer to a reserve status, subject to recall to military duty without going through the channels of the selective service. A holder of a Certificate of Service, Form 280, may eventually receive a discharge certificate; but the holder of an honorable discharge certificate (Form No. 55, War Department) will not be supplied a Form 280. (November 19, 1943.)



6046. ELIGIBILITY REQUIREMENTS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE PERTAINING TO APPLICANTS RETIRED FROM THE ARMED FORCES:--(A) Under Emergency Officers Retirement Act - Officers retired for disability under this Act are entitled to hospital treatment or domiciliary care if they meet the requirements of R. & P. R-6047 (A), (C) or (E), as itemized in R. & P. 6044. Form P-10 will be executed and eligibility determined as for applicants discharged from the armed forces. Reduction of retirement pay under the provisions of Veterans Regulation No. 6 (c), paragraph VI, will be made for such beneficiaries receiving hospital treatment or domiciliary care authorized by the Veterans Administration.

(B) Under Public No. 198, 76th Congress.--(1) Officers or enlisted men, including nurses, retired from the Regular Establishment (Army, Navy, Marine Corps, Coast Guard), including Fleet Naval Reservists and Marine Corps Reservists on retainer pay, who served honorably in a war, as defined in R. & P. R-6047 (A) and R-2694 (A) are entitled to hospital treatment and domiciliary care on a parity with other war veterans.

(2) Form P-10 will be executed by these applicants. The data for determination of eligibility will be procured as provided in R. & P. 6041, and from them it can be ascertained whether the condition for which hospital treatment is being requested is or is not service-connected.

(3) Hospital treatment can be provided for a service-connected condition under R. & P. R-6047 (A), subject to the requirements itemized in R. & P. 6044 (A); and for a condition not attributable to military or naval service under R. & P. R-6047 (C) or (E), as itemized in R. & P. 6044 (D) and (F). Domiciliary care can be provided under R. & P. R-6047 (C) or (E), as itemized in R. & P. 6044 (D) and (E).

(4) Under the terms of Public No. 365, 77th Congress, hospital treatment for such retired personnel can be authorized by the Veterans Administration not only in a facility under its direct and exclusive jurisdiction, but also in other Government hospitals that may be allocated to regional offices (including those a part of a facility). If such applicants be presenting a medical emergency growing out of a disease or injury incurred in a war period, and their condition forbids travel to a facility under direct and exclusive jurisdiction of the Veterans Administration or other Government hospital that may be allocated, admission to a contract civilian hospital can be authorized.

(5) Such retired personnel will be entitled to the furnishing of transportation to and from a facility under the same terms it is supplied war veterans; and, while receiving hospital treatment or domiciliary care from the Veterans Administration, they will have potential eligibility for personal clothing, toilet articles, tobacco, etc.; for orthopedic or prosthetic appliances of a permanent type; and for dental services authorized for other hospitalized or domiciled war veterans.

(6) While hospitalized or domiciled by the Veterans Administration in a facility under its direct and exclusive jurisdiction, such retired personnel will be subject to the provisions of paragraph VI (a), Veterans Regulation No. 6 (c), requiring reduction of monetary benefits for those with no dependents. This reduction of retirement pay will be made by the service from which the person was retired. To facilitate this, Form 404, in triplicate, will be prepared within 24 hours after admission of all such retired persons. The preparation and submittal of that form will not be withheld because such person alleges he has dependents. The original will be mailed (by air mail from trans-Mississippi facilities) to the [Field Branch, Bureau of Supplies and Accounts (Master Accounts Division) Cleveland 15, Ohio,] if the person



had been retired from the Navy or Marine Corps; to the Finance Officer, United States Army, Washington 25, D. C., if the person had been retired from the Army; and to the Commandant, United States Coast Guard, Washington 25, D. C., if retirement was from the Coast Guard. In preparing Form 404 for these admissions, there will be typed out the words, "Compensation, pension or emergency officers," before the words "Retirement pay" in question 4; and the words, "and Veterans Administration office having custody of your case file," in question 5. The day of admission will be entered on line (a) above the certification of the "Officer in charge." Form 404 will be similarly executed and forwarded when such retired officer or retired enlisted man is discharged from the facility, dropped from the rolls, or furloughed for 30 days or more. The amount to be deducted (that is, whether to \$20.00 or to \$8.00 monthly) during hospital treatment or domiciliary care is dependent, not upon whether the disease or injury for which hospital treatment or domiciliary care was furnished is service-connected or not service-connected, but upon whether the disability for which the beneficiary was retired is service-connected or not service-connected. (January 1, 1944.)

(C) Under Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress--(1) As provided in section 5, Public No. 18, 76th Congress, all officers, warrant officers and enlisted men of the Army (other than Regular Establishment) who, on or after April 3, 1939, had been called into active military service of the Federal Government, for extended active duty in excess of thirty days, and who, while so serving, suffered disability in line of duty, will be entitled to the same hospital benefits as are provided for "Corresponding grades and length of service in the Regular Army" (see also R. & P. R-1001(K)). As provided in Public No. 262, 77th Congress, on and after September 26, 1941, Reserve Officers of the Army who were called into active military service of the Federal Government, for extended active duty in excess of thirty days, on or subsequent to February 28, 1925, and other than for service with the Civilian Conservation Corps, and who, while so serving, sustained a disability in line of duty, will be entitled to the said hospital benefit.

(2) Persons so retired may upon application be furnished hospital treatment in a facility under direct and exclusive jurisdiction of the Veterans Administration, if they elect such in preference to an Army hospital. Since such hospitalization is not made under R. & P. R-6047 and 6048, the execution of a Form P-10 is not necessary; but the applicant, as a condition of admission, will be required to execute an agreement to pay the stipulated per diem rate charged by the Veterans Administration for his hospital treatment.

(3) The form of agreement to be so executed will read:

"As a condition of my admission for hospital treatment, as a person retired under Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress, to Veterans Administration facility at \_\_\_\_\_, I agree to a per diem

(Location) \_\_\_\_\_

charge of \_\_\_\_\_ for each day of such hospitalization; and, should I fail promptly to pay accounts therefor which are rendered me, I consent to deduction of the amount so due from the retirement payments being made to me."

Date \_\_\_\_\_

(Signature) \_\_\_\_\_

This signed agreement will be placed in the facility correspondence file related to such hospitalized person. Should he fail to pay bills as presented, the director of finance will be so informed.



(4) Form 1216, Account of Sale or Collection, will be used in billing such persons. The agent cashier will furnish executed Form 1028, Field Service Receipt for Remittance, to cover payments.

(5) Conforming to the provisions of paragraph 6 b (1), Army Regulations 40-590, the hospital treatment for such retired personnel will be limited to cases which, in the judgment of the chief medical officer or clinical director or their designates, will require hospitalization for only a reasonable time. Applicants with chronic invalidism, whose hospitalization would be unduly prolonged, will not be accepted. Exception will be made for tuberculous applicants. A courteous explanation of the reason will be made to any rejected applicant.

(6) The per diem rate to be charged such persons (representing a subsistence charge and conforming to current Army rates) will be \$1.00 for officers suffering from general medical and surgical disorders, and \$1.50 for tuberculous patients. This rate will not include cost of blood transfusions, nor any dental treatment other than emergency measures to relieve pain (that is, no artificial dentures or bridge work). Orthopedic and prosthetic appliances of a permanent type will not be supplied, and those patients will not be furnished personal clothing, toilet articles, tobacco, shaving, etc. Transportation to and from the hospital will be at the expense of the patient. For burial of such patient who dies while hospitalized by the V. A., see Veterans Regulation No. 9 (b), paragraph III, as amended by section 2 (a), Public No. 866, 76th Congress. See also R. & P. 8137 as to shipment of body.

(7) Domiciliary care is not authorized for these retired applicants. (August 1, 1942.)

(8) Should such applicants for hospital treatment have had previous service in a period of war (as in World War I, or on and after December 7, 1941, in World War II) their potential eligibility for hospital treatment or domiciliary care will be determined under R. & P. R-6047 (A), (C) or (E), and no per diem rate as provided will be charged. Form P-10 will be filed in such cases. (November 19, 1943.)

6048. ACTION WHEN FRAUD IS SUSPECTED IN APPLICATIONS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.--(A) If discrepancies are noted between the sworn statements on an applicant's Form P-10 and data secured for determination of his eligibility for hospital treatment or domiciliary care, the manager (in accordance with R. & P. 1557) will ask the applicant to make a written statement in explanation, which will be signed by him under oath. Accompanied by a letter of transmittal, embodying the manager's comment and recommendation, and citing R. & P. 1557 and this paragraph, that sworn statement will be referred by registered mail, to the station having custody of the applicant's case file. Should the person have been admitted before the fraud was suspected and have left the hospital before he could be asked to furnish the explanatory statement; or, if for any other reason such sworn statement cannot be procured, the Form P-10 and originals of any other forms, papers, etc., relevant to the inquiry will be sent, as provided, to the station aforesaid, for development of the inquiry as prescribed in R. & P. 1557. If the case file be in central office, or if there be no case file, the sworn explanatory statement of the applicant or beneficiary, together with his Form P-10 in question, and the aforesaid letter of transmittal from the manager, will be sent to the committee on waivers and forfeitures, central office, for the required action.



(B) If, for a mentally incompetent or for an unconscious or moribund applicant, Form P-10 was executed and sworn to by a representative or guardian, the action outlined in (A) will be directed to such representative or guardian. (August 1, 1942.)

6049. RIGHT TO HOSPITAL TREATMENT FROM OTHER SOURCES.--[Any person defined in R. & P. R-6048 (C) who applies for hospital treatment of a condition not attributable to military or naval service may be furnished hospital treatment as a patient of the V. A. contingent upon agreement, at the time of admission, that he] will execute an assignment to the V. A. of any items of hospital treatment which are reimbursable under his plan, policy, etc. It is particularly important to determine whether any third party is liable, in procuring such assignment from the applicant. If any applicant declines to execute such assignment, hospitalization will be refused, unless his condition is so emergent that [such refusal will jeopardize his health or life. For details as to collection, etc., see R. & P. 4359]. (April 25, 1946.)



DETERMINATION OF NEED FOR HOSPITAL TREATMENT; TUMOR CLINICS; CENTERS FOR TROPICAL DISEASES; TRANSPORTATION IN ADMISSIONS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.

6050. HOSPITAL TREATMENT.--(A) See R. & P. 6042 (B) as to medical determinations following upon receipt of executed Forms P-10, Application for Hospital Treatment or Domiciliary Care. The physician responsible for such determinations must have full familiarity with the provisions of R. & P. R-6047, and the interpretative instructions in R-6048. With the heavy demand for beds in mind, he will not approve admission for hospital treatment when, in his judgment, the applicant needs no hospitalization or his condition if service connected can be treated on an out-patient status. Inactive tuberculosis, pulmonary or extra-pulmonary, will not ordinarily require hospital treatment. Hospitalization is regarded as inadvisable for any other than severe forms of psychoneuroses, when out-patient treatment has not produced improvement. Psychopathic personality or mental deficiency, without superimposed psychosis or psychoneurosis, will not require hospital treatment (but may entitle to domiciliary care if producing material social or industrial inadaptability).

(B) For administrative reasons hospital admission may be necessitated when the nature of the condition is such that it might otherwise be treated in an out-patient unit. Instances are spinal or venous puncture for treatment or diagnostic purposes, induction of artificial pneumothorax, etc., such hospitalization will be essentially temporary, the patients being discharged as soon as the service is completed and reactions observed. (August 1, 1942.)

(C) The need for readmission will have the same attention. A beneficiary who had been discharged cured or improved or with maximum benefit, from a previous episode of hospitalization, will ordinarily not need rehospitalization within six months thereafter, except for a severe reactivation of the original disorder, or intercurrent of some other unrelated, acute condition. Readmissions under R. & P. R-6100 (B) - recall of discharged patients to note progress or modify treatment (as re-irradiation of tumors, refills of artificial pneumothorax, fitting of orthopedic appliances or artificial dentures, etc.) - [may be authorized by the medical head of the facility at which the original treatment had been rendered, who will determine the need for such follow-up readmission and appoint the dates for them. However, for any medical service mentioned which can be rendered thereat with more convenience and less travel expense, such patient may be readmitted instead to a facility which is nearer his place of permanent residence. Authority for this action will rest with the manager of such nearer facility, and if his proposed action is counter to arrangements made for readmission to the facility of first instance, the manager of the latter will be informed of the proposed change in the facility for readmission.] (December 31, 1943.)

6051. DOMICILIARY CARE.--(A) Understanding of the requirements attaching to provision of domiciliary care as differentiated from hospital treatment is essential, when it is proposed to refer an applicant for domiciliary care to a facility adapted primarily therefor, or to effect inter-facility transfer to such facility of a patient who has completed hospital treatment at another facility. The regulatory provisions pertaining to the most common type of admissions, viz., of war veterans under R. & P. R-6047 (E), illustrate this difference. The applicant desiring domiciliary care is required to have a condition essentially chronic in character, not susceptible of cure or decided improvement by hospital treatment, and producing disablement of such degree and of such probable persistency as will incapacitate him from earning a living for a prospective period. Other criteria - such as the definition of "A permanent disability," in R-6048 (A)(1) and (2), and of "Any disability, disease or defect," in R-6048 (B)(1)--are further to be regarded. Bene-



ficiaries who, admitted for hospital treatment after meeting the requirements of R-6047 (A) or (B), request transfer to domiciliary care, will not be eligible therefor until they have satisfied the requirements of R. & P. R-6047 (C), (D) or (E), as interpreted by R. & P. R-6048.

(B) At most facilities primarily for domiciliary care, members, dependent upon whether their condition allows of assignment to work details, are assigned to "duty" or "non-duty" barracks, respectively. A member housed in "duty" barracks, though required to have sufficient disability to justify domiciliation, must need no nursing or hospital attendant care and no special dietary regimen. He must be able to mount or descend stairs, walk some distance to the general mess hall, feed and dress himself, and do light work. While members housed in "non-duty" barracks are of the more disabled type and are not required to perform work details, they also are furnished only limited care by domiciliary attendants, and are not supplied nursing, special diets, etc. When the condition of domiciled members becomes such that daily sick call and visits to the clinic are not sufficient to meet treatment needs, they are sent to the station hospital. The hospital patients are also of two classes: those needing active treatment, calling for a full complement of physicians, nurses and hospital attendants; and those of the convalescent or chronic classes, who require less medical, nursing and attendant care.

(C) That an applicant desires domiciliary care must be made clear by careful deletion of the parenthetical clause "(hospital treatment)", opposite question 1, Form P-10. If, in an executed Form P-10 returned by mail, this indication of the applicant's desire is not clear, the Form P-10 will be returned to him, with request that he signify unmistakably what benefit he is applying for. The limitations upon furnishing transportation, without prior consent of the director of national homes, incident to discharge, transfer and readmission of domiciled members is an additional reason for requiring clarity in applying for domiciliary care. (August 1, 1942.)

6052. TYPES AND ALLOCATION OF FACILITIES.--(A) The types of activities in each field station of the Veterans Administration are listed in Bulletin No. 31 series, which is revised at intervals to accord with the opening of new, and the conversion or evacuation (temporary or permanent) of old facilities, etc. The listing by location, includes hospital facilities with and without regional office activities; facilities primarily for domiciliary care but with hospital beds, with and without regional office activities; and regional offices, solely. The clinical type or types of patients which can be furnished continuous treatment at any such facility is stated, with designation of such as have beds for women and for negro beneficiaries. Diagnostic centers and tumor clinics are included.

(B) The allocations of facilities is listed in Bulletin No. 24 series, which is revised as necessitated by changed conditions. This allocation includes not only facilities under the direct and exclusive jurisdiction of the Veterans Administration, but other Federal hospitals assigned to specified regional offices.

(C) The nearest facility which is adapted for the requisite hospital treatment or domiciliary care, and which has an available bed, is to be selected by the field station receiving Form P-10, application for either such benefit. In medical emergency, admission will be made to any facility, subject to later transfer of the patient to another facility for such continued treatment as is needed after termination of treatment for his emergent condition.

(D) For observation and physical examination, the nearest suitable facility or diagnostic center will be used. Facilities primarily for neuropsychiatric patients have separate limited accommodations for mentally competent claimants or beneficiaries who are to be authorized hospital observation and physical examination for disability rating purposes.



(E) When in doubt as to availability of a bed in a facility to which an applicant is to be sent, the referring station will make inquiry upon the manager of the facility proposed for admission, before forwarding the Form P-10.] (August 1, 1942.)

6053. [FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--(A) See R. & P. R-6050; full familiarity with and close adherence to its provisions are enjoined. Managers of insular and regional offices (including those a part of a facility) will procure proposals for furnishing such contract hospital treatment for eligibles as will meet estimated regional needs. When contracts are approved, the superintendents of such hospitals will be carefully instructed as to authorizations, etc. Officers of ex-service men's organizations and other welfare agencies will be advised as to the procedure which necessarily pertains to admission of beneficiaries to contract hospitals. It will be emphasized that prior authorizations must be obtained from the chief medical officer or his designate; that such requests will have prompt attention by him; that he must determine the need for and authorize the conditions under which any hospital service or attendance of a private physician are procured; and that such authorizations cannot be retrodated. Chief medical officers will make arrangements whereby requests for emergency admissions to contract hospitals can be handled after close of official hours, that is, during the night or on Sundays and holidays. Whether an applicant in an emergent condition can travel to the nearest facility under direct and exclusive jurisdiction of the Veterans Administration or other Government hospital allocated to the station will always have due consideration before admission to a contract hospital is authorized.

(B) Admissions to civilian hospitals, of male beneficiaries within the continental limits of the United States, will be for service-connected conditions only; they will not be authorized for adjunct treatment (that is, treatment of a nonservice-connected disorder which is associated with the basic service-connected disease or injury). Admissions for such adjunct treatment will be made (under R. & P. R-6047 (C), (D) or (E)) to facilities under direct and exclusive jurisdiction of the Veterans Administration whenever possible, or in other Government hospitals which are allocated to the regional territory. If a male beneficiary, while receiving authorized treatment in a civilian hospital for a service-connected disease or injury, develops an intercurrent condition not service-connected, his transfer to a Government hospital (and preferably a facility under direct and exclusive jurisdiction of the Veterans Administration) will be made, if he can safely travel. If it is determined that his condition interdicts travel, the chief medical officer may authorize necessary adjunct treatment in the hospital where the beneficiary is under treatment.

(C) Women war veterans may be authorized admission to a civilian hospital for adjunct treatment; and will be entitled to such continuance of hospitalization as is necessary for an adjunct condition which arose during their authorized hospital treatment for some other disease or injury.

(D) Auxiliary treatment, that is, the treatment of a nonservice-connected condition associated with a basic nonservice-connected disease or injury, can be authorized, in civilian hospitals, only for women war veterans. Transfer to a Government hospital (preferably a facility under direct and exclusive jurisdiction of the Veterans Administration) will be considered, if travel can safely be made and economy can be served.] (August 1, 1942.)



## SPECIAL FACILITIES.

6054. [DIAGNOSTIC CENTERS.—(A) Territorial allocations for the three diagnostic centers - located, respectively, in Washington, D. C., Hines, Illinois and San Francisco, California - have not been made. Admissions will be made to the center which is nearest the referring station. Authority for such admissions has been fully decentralized, subject to observance of the provisions hereof; and that authority may be exercised (1) by the chief medical officer or clinical director of a field station, who desires definitive advice regarding the identity and treatment of the condition of a patient which have remained obscure after exhaustion of all diagnostic resources at his station; and (2) by a chief medical officer, when requested by the adjudication officer of his field station, or by central office.

(B) Diagnostic centers - which have a consulting staff of specialists of national reputation - were created for study of problem cases, regarding which no satisfactory conclusion can be reached, or irreconcilable differences of medical opinion exist, at other field stations. The centers will be the final resort for establishing definitive diagnosis or indicated treatment in controversial cases. The responsibilities of the centers will be purely medical, and will not involve adjudication of disability claims, except insofar as such medical opinion relates to the subsequent determinations of rating agencies. The essential functions of the centers will be the definitive determination of a diagnosis, with delineation of supporting symptoms and physical findings, and with recommendations for treatment, if requested. The findings and conclusions of each specialist of the center will be coordinated with those of his conferees, before the final, full report is forwarded for consideration by a disability rating unit. Such reports are to be accepted by adjudication agencies as superior to and superseding all previous reports from other sources. While opinion as to the probable origin and cause of a disorder, based upon its history and clinical evolution, may be expressed by the centers, for consideration of adjudication agencies, estimates of the extent of disability in percentage terms, or questions of service connection, or of the comparative weights and sufficiency of the evidence for rating purposes will not be within the province of diagnostic centers. They will not be asked to assume those responsibilities, which legitimately attach to disability rating boards. Upon request of an adjudication agency, however, opinion may be tendered for consideration as to the character of a disease or injury in what is to be understood as medical terms, that is, whether its clinical expression is mild, moderate, moderately severe, severe, or pronounced.

(C) Diagnostic centers will consider submittals, from medical members of the board of veterans appeals or of rating boards, or other physicians of the Veterans Administration, reflecting difference of opinion, on a medical point, in respect to a report from a center. Such submittals, written and transmitted through channels, will clearly and with sufficient fulness set forth the medical issue, and the reasons for contrary opinion. The claimant or beneficiary in the case will not be returned to the diagnostic center concerned, nor will his case file be so returned, unless requested by the center. If the difference of opinion cannot be reconciled upon reconsideration of the case by the center, then the case file, with a summary of the point at issue, will be referred by the rating board, facility or office concerned, to the medical director, whose arbitrament will be accepted and constitute the basis for subsequent action by any agency of the Veterans Administration.



(D) Case files of claimants or beneficiaries referred to diagnostic centers will be forwarded to the centers, and to effectuate so far as possible the coincident receipt of the claimant or beneficiary and his case file, this procedure will be observed:

(1) The regional office, including one which is a part of a facility, will forward the case file, if in possession thereof, at the same time that Form 2557, Admission Card, is sent to the center to authorize the admission.

(2) If the case file of a claimant or beneficiary who is to be referred to either the center at Hines or that at San Francisco, is in central office, the station that is making the reference will notify the chief clerk, central office, by air mail or special delivery letter that he is authorizing such admission, and will request forwarding of the case file of the claimant or beneficiary (full name and C-number) to the said center.

(3) If the case file of a claimant or beneficiary who is being authorized admission to the center in Washington, D. C., is in central office, the manager of the facility will telephone the chief clerk, central office, who will arrange for delivery of the case file to the center.

(4) When a case file is so received by a diagnostic center, and the claimant or beneficiary has not reported there within ten days after the date on Form 2557, Admission Card, the file will be returned to the station that forwarded it, unless the center is meanwhile informed by the referring station that extension of time to report at the center has been granted the claimant or beneficiary for sufficient reason, and the approximate date of his delayed arrival is stated. (August 1, 1942.)

6055. CHEST SURGERY CENTERS.--(A) These, located in the facilities at Castle Point, New York; Hines, Illinois; Legion, Texas; Oteen, North Carolina; Portland, Oregon; San Fernando and Livermore, California; Tucson, Arizona; and Washington, D.C., were established for the performance of such major chest surgery and surgical collapse measures in pulmonary tuberculosis and non-tuberculous pulmonary conditions as are not within the resources of other facilities.

(B) In all facilities primarily for tuberculous patients, a "Surgical Collapse Board," composed of five members - the chief medical officer or clinical director, a roentgenologist, a chest surgeon, a specialist in tuberculosis and a ward physician - is to be organized. In units for tuberculous patients in other facilities, such boards will similarly be organized, with a composition conforming as closely as possible. Patients admitted for treatment of pulmonary tuberculosis are to be examined, while they are in the reception ward, by such boards. If the board decides that a patient's condition requires medical treatment only, that patient will be scheduled for re-examination at an appropriate future date, but not later than three months, to note his response to the regimen. If it then be found that no improvement has taken place, thoughtful consideration should be given to the employment of some type of collapse therapy (e.g., artificial pneumothorax, etc.). If, upon the first examination of a patient the board finds his condition so far advanced, or exhibiting such complications as contraindicate collapse therapy, the ward physician will be informed that such patient will not be scheduled for periodic future examinations by the board. However, ward physicians are at liberty to request opinion of the surgical collapse board at any time and in any case; and patients whose condition shows slight or no improvement under the medical treatment routine, or who evidence any trend toward retrogression, should have the benefit of a board study.



(C) If such facility lacks equipment or personnel to undertake major chest surgery, its chief medical officer or clinical director will consider transfer of the patient concerned to that chest surgery center nearest his station. A full set of roentgenograms of the patient's chest, together with a sufficient summary of his history, symptoms, physical findings and treatment will first be forwarded to such center, with request for opinion as to the advisability of transferring the patient for surgical treatment at the center. The opinion received in reply will determine whether the patient is to be transferred or retained. Should the patient be transferred to a chest center and there, after recovery from surgical treatment, it be decided that he needs resumption of medical treatment, he may be retransferred to the station that referred him to the center. (August 1, 1942.)

6056. TUMOR CLINICS.--(A) These are located in the facilities at Hines, Illinois; Bronx, New York City; Atlanta, Georgia; Washington, D. C.; Portland, Oregon; and Los Angeles, California. Treatments by radium element and deep X-rays are available at all of these [clinics; and radon implants can be supplied them, upon request, from the radium emanation laboratory at Hines, shipments being made by air mail].

(B) These tumor clinics have no territorial allocations, for general reference [of patients. They are authorized to make direct admissions or to accept patients transferred from other facilities. Other facilities proposing such transfers will use the nearest tumor clinic, except as regards laryngeal carcinoma. Admissions of patients with laryngeal carcinoma] will be allocated as follows:

(1) To the tumor clinic, Bronx, New York City, patients from the New England States, New York, New Jersey and Pennsylvania. (2) To the tumor clinic in the facility at Washington, D. C., patients from Delaware, Maryland, Virginia, West Virginia, District of Columbia, the Carolinas, Georgia, Alabama and Florida. (3) To the tumor clinic at Hines, Illinois, patients [from all other states, regardless of travel distance or greater nearness of other tumor clinics. Proper selection will be made of patients with laryngeal carcinoma proposed for transfer to Hines. Suitable for such reference would be, not only intrinsic lesions, (that is, involving the true cords), but extrinsic varieties, affecting the epiglottis, pharynx, arytenoid cartilage, pyriform fossa or vallecula. But patients with metastases to the submaxillary, submental or cervical glands, or who have perforation of the cartilage with extra-laryngeal extension are not likely to be benefited, and their transfer is ordinarily inadvisable. The general physical condition of the patient is also to be considered, especially as related to the fatigue of travel. The mental effect of separation from relatives and friends is also to be weighed. If the decision is against transfer to Hines, treatment will be continued at the tumor clinic where the patient is hospitalized.] (December 31, 1943.)

(C) Applicants for hospital treatment of tumors will be admitted, if otherwise eligible, to the facility where these applications are first received. They will be retained there for a time sufficient to establish whether the tumor be benign or malignant. If benign, they will be given the necessary surgical or other treatment that is available at that station, or be transferred to the nearest suitable other facility for such attention. If the tumor be malignant, transfer to the nearest tumor clinic (except as to cases of laryngeal involvement, as provided) will be effected, provided chief medical officers or clinical directors concerned feel assured that the condition is not terminal, and that the beneficiary can travel the necessary



distance with safety. In such transfer to a tumor clinic, the facility of reference will supply such historical and diagnostic data as it can develop, e.g., duration of the condition, its relative rapidity of spread, whether it had been treated and by whom and how (irradiation, surgery), together with report of any biopsy that has been made at the referring facility and any tissue slides or photographs, radiographs, etc., that have been prepared. If at the facility to which such patient was originally admitted, there is doubt as to malignancy of the growth or as to the advisability of attempting therapy, the chief medical officer of the nearest tumor clinic will be asked for an advisory opinion, and will be supplied informative data such as described in the foregoing. (August 1, 1942.)

(D) A report of the diagnosis, findings, treatment and prognosis related to a patient who has been transferred to a tumor clinic, will be supplied by that clinic, upon completion of its treatment, to the facility that had transferred the patient to the clinic. And if a tumor clinic refers a patient, for continued treatment, to another facility, the manager thereof will be supplied a like report. (December 31, 1943.)

6057. ALLERGY CLINIC.—This clinic and laboratory is established in the facility at Pittsburgh, Pennsylvania. Sets of stock allergens may be requisitioned from the manager of that station, and autogenous allergens are similarly obtainable upon special requisitions, accompanied by material to be used in their preparation. Courses of training in the diagnosis and treatment of allergic conjunctivitis, dermatosis, intestinal disorders, hay fever and bronchial asthma, can be arranged, for periods of one month. Nomination of physicians in facilities or regional offices best qualified by interest and experience to be given such training will be made to the medical director by chief medical officers or clinical directors of stations at which a sufficient volume of allergic patients are encountered. If the nominations (to be accompanied by a brief of the nominee's qualifications) are acceptable, the medical director will authorize and arrange the training course. (August 1, 1942.)

6058. INSTALLATIONS OF RESPIRATION APPARATUS.—Resuscitation and respiration apparatus of the "Iron Lung" type have been installed in the facilities at Atlanta, Georgia; Bronx, New York City; Hines, Illinois; and Los Angeles, California. For patients requiring continued artificial respiration, emergency transfers may be arranged to the nearest of such facilities; or, when travel of the patient is not possible, the apparatus may be shipped to the facility where the patient had been admitted. All arrangements will be made directly between chief medical officers or clinical directors concerned. (August 1, 1942.)

6059. FACILITIES FOR MALARIA TREATMENT OF NEUROSYPHILIS IN NON-PSYCHOTIC PATIENTS. Besides the facilities primarily for neuropsychiatric patients at which malaria therapy of neurosyphilis is available for psychotic beneficiaries, the following stations have been equipped to render malaria treatment for non-psychotic patients suffering from neurosyphilis:

- Veterans Administration Facility, Bronx, New York City
- Veterans Administration Facility, Dayton, Ohio
- Veterans Administration Facility, Los Angeles, Calif.
- Veterans Administration Facility, Wadsworth, Kansas

Admissions for such treatment to the nearest of these facilities can be authorized under the decentralized authority to effect inter-facility transfers. But, in exercising that authority, due care will be taken at the referring facility to deter-



mine the indication for this treatment in the individual cases. If there is doubt on this point, the question should be settled with the chief medical officer of the facility to which transfer of the patient is proposed, who will be furnished a sufficient summary of the history, physical findings and symptoms in the case. (August 1, 1942.)

6060. CENTERS FOR DIAGNOSIS AND TREATMENT OF TROPICAL DISEASES.--The hospitals in the Bronx, New York City; Washington, D. C., (Naval Hospital, Bethesda, Maryland); Biloxi, Mississippi; [ ] San Francisco, California, [and Hines, Illinois,] have been designated as centers for the diagnosis and treatment of problem cases of tropical diseases. If, to any facility there has been admitted an ex-member of the armed forces suffering from a tropical disease; and it is the opinion of the chief medical officer or clinical director thereof that the resources of the station are not adequate for the diagnosis and treatment of the patient, his transfer to the nearest of any of the foregoing named centers may be effected under the decentralized authority for inter-facility transfers. It will be essential that the availability of a bed in the center proposed for the transfer be ascertained in advance, because no specified number of beds have been set aside for such patients in the said centers. (March 22, 1944.)

6061. LABORATORY CENTERS.--(A) These are housed in the facilities at San Francisco, California; Hines, Illinois; Bronx, New York City; and Washington, D. C. All correspondence regarding laboratory service desired by any field station that cannot be accomplished by its present personnel or equipment, will be addressed to the manager of the nearest such center, which can supply the following among the services: Anti-sheep amboceptor and antigen for the Wassermann test; normal n/10 and n/100 solutions of acids and alkalis; cultures of typhoid and paratyphoid bacilli; chemical analysis of water; performance of Wassermann, Kahn and flocculation tests; gonococcus complement fixation test; other chemical or bacteriological tests; histo-pathological examinations of tissues removed at necropsy, biopsy or surgical operation. See shipment of autopsy material. (August 1, 1942.)

(B) When slides or specimens are sent for opinion to a laboratory center, they will be accompanied, for information of the pathologist, by data as to the name, C-number and hospital register number (if any) of the patient, the anatomical source of the material, and a sufficient summary of the history and clinical features of the patient. (December 31, 1943.)

#### FORMS FOR AUTHORIZING HOSPITALIZATION OR DOMICILIATION

6062. (A) HOSPITAL OBSERVATION AND PHYSICAL EXAMINATION - Form 2557, Admission Card, will be used by regional offices (including those which are a part of a facility) in authorizing admissions to a facility, including diagnostic centers, for observation and physical examination. That form will similarly be employed by facilities in referring patients to a diagnostic center for advisory opinion. Form 2557 will be used for the same purpose when hospital examination is requested by other Federal agencies.

(B) HOSPITAL TREATMENT OR DOMICILIARY CARE:--(1) Form P-10, approved, will be the authorization of admission for hospital treatment or domiciliary care, in a facility under direct and exclusive jurisdiction of the Veterans Administration, of persons discharged from the armed forces of the United States, including Emergency



Officers, World War, (retired under Public No. 506, 70th Congress), and applicants retired from the Army, Navy, Marine Corps or Coast Guard, who had service in a war, and are applying for hospital treatment or domiciliary care authorized under Public No. 198, 76th Congress, as amended by Public No. 365, 77th Congress.

(2) Form 2557, Admission Card, will be used by regional offices, including those which are a part of a facility, in authorizing hospital treatment in facilities other than those under direct and exclusive jurisdiction of the Veterans Administration. Form P-10, however, will be executed by such applicants and will be the basis, if approved, for such issuance of Form 2557.

(3) Form 2557 will be used to authorize hospital treatment of other than applicants named in (1), such as beneficiaries of the United States Employees Compensation Commission; enrollees of and officers and enlisted men attached to the Civilian Conservation Corps; employees of the Work Projects Administration or National Youth Administration; persons in active service with the Army, Navy or Marine Corps; beneficiaries of the United States Public Health Service; Canadian and British Imperial Pensioners; and applicants retired under Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress (see R. & P. 6046). (August 1, 1942.) (Paragraph 6062 continued.)







## TRANSPORTATION IN ADMISSION FOR HOSPITALIZATION OR DOMICILIATION

6065. [OFFICIALS EMPOWERED TO AUTHORIZE TRANSPORTATION.--(A) Transportation at Government expense to cover travel to a facility, of claimants or beneficiaries, for hospital observation and physical examination, may be authorized by the manager or by the chief medical officer and his designates in an insular or in a regional office, including one that is a part of a facility.

(B) Transportation to cover travel to a facility, under direct and exclusive jurisdiction of the Veterans Administration, of an accepted applicant for hospital treatment or domiciliary care, may be authorized by the manager or by the chief medical officer or clinical director and their designates, in such facility.

(C) Transportation to cover travel to a facility, other than one under direct and exclusive jurisdiction of the Veterans Administration, for hospital treatment, may be authorized by the manager, or chief medical officer and his designates, in insular and in regional offices, including those which are a part of a facility.

(D) A manager's power to authorize transportation incident to hospitalization or domiciliary care is expected to be exercised ordinarily through the chief medical officer, clinical director or their designates.] (February 26, 1943.)

6066. [TRANSPORTATION IN ADMISSIONS FOR HOSPITALIZATION OR DOMICILIARY CARE.-- See R. & P. R-6100. Transportation to cover admission for hospitalization or domiciliary care may be supplied as follows, when there is no uncleared period of exclusion because of previous discharge for infraction of facility discipline, or affidavit of inability to defray expense of such transportation is executed (on Form P-10 or as otherwise provided) by a claimant or beneficiary in such uncleared disciplinary status:--

(A) Hospital Observation and Physical Examination.--(1) A claimant or beneficiary who is being authorized admission to a facility or diagnostic center for observation and examination for purposes of disability compensation, pension, emergency officers' retirement or Government Insurance (including World War applicants for reinstatement and applicants for National Service Life Insurance), may be supplied transportation to cover travel to the station selected.

(2) When hospital observation and examination of a plaintiff in a suit for Government Insurance is requested by the Bureau of War Risk Insurance Litigation, Department of Justice, transportation may be supplied. But the Veterans Administration will not supply transportation to cover travel to a facility for hospital observation and examination provided upon request of other Federal agencies, such as the United States Civil Service Commission, the Employees Compensation Commission, the Railroad Retirement Board, etc.

(3) Pensioners of Canada or Great Britain, when hospitalized for observation and physical examination upon requests of accredited officials, will be supplied transportation to effect travel to the selected facility, subject to reimbursement by the respective government. Mileage allowance (see R. & P. 6074) can be furnished these pensioners, if requested.

(B) Hospital Treatment - (1) An applicant found eligible under R. & P. R-6047 (A) or (B) for hospital treatment of a service-connected disease or injury may be supplied transportation to accomplish admission for that purpose.



(2) An applicant who is being separated from the Army for disability in line of duty and is being referred by the Army for hospital treatment by the Veterans Administration, will be delivered at a facility designated by the medical director, with transportation, including any needed attendant, at expense of the Army.

(3) An applicant found eligible under R. & P. R-6047 (C), (D) or (E) for hospital treatment of a disease or injury not attributable to military or naval service, may be supplied transportation to cover travel to a facility for that purpose, provided he has made sworn statement on Form P-10 that he is unable to defray the expense of the travel. (See R. & P. 6078 as to execution of Form P-10 in emergency admissions.)

(4) An accepted applicant who, while en route for authorized admission to a Federal hospital, becomes too ill to complete travel thereto, may be authorized admission to a contract hospital in the regional territory where interruption of the original travel occurred; and may be furnished transportation, ambulance or other, to such contract hospital.

(5) An applicant retired from the regular establishment under Public No. 198, 76th Congress, as amended by Public No. 365, 77th Congress, is entitled to transportation for hospital treatment under the same conditions attaching to any other veteran of a war.

(6) An applicant retired from the United States Army, not regular establishment (Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress), and who had had no former war service, will not be supplied transportation by the Veterans Administration to effect hospital treatment in one of its facilities.

(7) An applicant in active service with the United States Army or Navy will not be provided transportation by the Veterans Administration incident to his admission to one of its facilities.

(8) A beneficiary of another Federal agency (e.g., United States Public Health Service, Employees Compensation Commission) will not be supplied transportation by the Veterans Administration to cover travel to one of its facilities for hospital treatment requested by such agency.

(9) Pensioners of Canada or Great Britain may be supplied transportation to cover travel to a facility for requested hospital treatment, subject to reimbursement from the respective government.

(C) Domiciliary Care - An applicant for original admission to domiciliary care may be provided transportation to the facility selected therefor, provided he has made sworn statement on Form P-10 that he is unable to defray the expense of such travel. (For readmission, see R. & P. 6067 (C).)

(D) Persons comprehended by (A) to (C) who are not otherwise furnished transportation at the expense of the Veterans Administration may, however, be carried in station vehicles from the junction of a common carrier to the facility of admission.】  
(February 26, 1943.)

6067. 【TRANSPORTATION IN READMISSIONS FOR HOSPITALIZATION OR DOMICILIARY CARE -  
(A) Hospital observation and physical examination - A claimant or beneficiary of the Veterans Administration who is being authorized readmission to a facility or diagnostic center for completion of observation and physical examination which had been interrupted by an irregular discharge from a previous episode of hospitalization for the same purpose, will not be entitled to transportation to effect such readmission, unless he alleges inability to defray the expense thereof and executes affidavit as provided in R. & P. 6079.



(B) Hospital Treatment - (1) Readmission to determine progress of a disorder, to modify treatment including diet, or to complete a medical service (as authorized in R. & P. R-6100 (B) and R. & P. 6050 (C)), will be authorized by the chief medical officer or clinical director or their designates in the facility concerned, with transportation at Government expense, if the beneficiary be not in disciplinary status. This authority will extend to any type of service which, in good judgment, is determined necessary. Instances are recalls to note recurrence, if any, of malignant growths and their re-irradiation; refills for artificial pneumothorax; fitting of an artificial limb or eye, or fitting of glasses following cataract extraction; furnishing of artificial dentures; regulation of insulin dosage, diet, etc.

A tumor clinic, instead of authorizing readmission directly to the clinic, may request the facility nearest the residence of the beneficiary to admit him for examination, to determine whether his condition actually requires recall to the tumor clinic. If so, interfacility transfer will follow.

(2) Readmission subsequent to an irregular discharge from a previous episode of hospital treatment, may be authorized, with transportation, if the period of exclusion imposed for the offense has expired.

(3) Readmission for hospital treatment before expiration of a period of exclusion imposed for infraction of discipline during a previous episode of hospital treatment or domiciliary care can be authorized only in a medical emergency; and no transportation for such readmission will be supplied unless the applicant alleges inability to defray the travel expense and takes oath accordingly. The applicant's sworn statement in answer to question 10, Form P-10, application for hospital treatment (the execution of which may be deferred in emergency until after hospital admission) that he is unable to defray the expense of transportation to the facility, will suffice, and an additional affidavit (R. & P. 6079) will not then be necessary.

(4) Readmission Following Elopement of a Psychotic Patient - (a) If such patient be apprehended at a point distant from the facility from which he eloped, the manager or chief medical officer of any station in the territory of which the patient is being held, as soon as informed thereof, will wire the facts to the medical director, who will consider the relative advantages of effecting rehospitalization in the territory where the patient is being held, or returning him to the facility from which he eloped. If the former action is determined upon, the officer who sent the wire will be requested to secure consent of the guardian (name and address to be supplied by the medical director), if any, or of the nearest relative, to local hospitalization; and, if the patient had been committed to the facility from which he had eloped, to notify the chief attorney of the jurisdiction in which the commitment had been made, so that he may procure, if possible, a clearance of the commitment. When informed that these preliminary steps, undertaken by him, have been attended to, the said manager or chief medical officer will effect rehospitalization of the detained patient in his or the nearest other suitable facility of his territory, and will inform the medical director and also the manager of the facility from which the elopement had occurred, accordingly. Such rehospitalization is expected to be made without commitment or recommitment, and will not require execution of a new Form P-10. Form 2557, Admission Card, will cover the readmission. The readmission will be reported on Form 2593, Record of Hospitalization or Domiciliary Care. The



station from which elopement had occurred, upon receipt of the said notification of readmission, will reflect formal discharge of the patient upon a completed Form 2593, and will notify the chief attorney of the completed action. (See preparation of Form 2593 for specific entries.)

(b) An eloped psychotic patient, if not apprehended as contemplated by (a) will not be discharged, but reported in elopement status, by Form 2593, until eventual clearance from the hospital rolls, as provided in R. & P. 6096 (L)(2).

(C) Domiciliary Care - The furnishing of transportation to effect readmission for domiciliary care will require prior approval of the director of national homes.】 (February 26, 1943.)

6068. 【TRANSPORTATION BETWEEN FACILITIES AND COMMON CARRIER JUNCTIONS - (A) Managers will arrange transportation, including station ambulance as needed, of expected claimants and beneficiaries from the junction of a common carrier to the facility. The chauffeur of the facility vehicle will be instructed to call at the information booth or ticket office at the junction, to assure himself that no claimant or beneficiary has been overlooked.

(B) When it is known in advance that the facility cannot send a station vehicle to meet an incoming beneficiary, he will be mailed a special transportation request, Form 3267, to procure such travel by taxi, if that is the only mode of conveyance available; or mailed local street car or bus tickets, if he can get to the facility by either such means, from the common carrier junction.】 (February 26, 1943.)

6070. 【FORMS USED IN DIRECTING TRAVEL IN ADMISSIONS FOR HOSPITAL TREATMENT OR DOMICILIARY CARE - Travel of claimants or beneficiaries, including accompaniment of attendants if determined necessary, must be authorized in advance, and the mode of travel (especially if ambulance or automobile is to be used) must clearly be so authorized. Forms to be used are these:

(A) Hospital Treatment - (1) Notice to an accepted applicant to report at a selected facility for hospital treatment may include:

Form 2511, Notice to Report for Hospitalization or Domiciliary Care (common carrier transportation at Government expense). In authorizing hospital treatment, care must be taken to specify it, so as to avoid confusion as to domiciliary care. R. & P. 8425, Supply, provides that regular transportation requests issued will bear the same date of issue as the travel order, and an expiration date which will not exceed 30 days from the date upon which the travel was authorized; and that regular lodging, special transportation, contract meal and lodging requests will bear the same expiration date as the regular transportation requests which they accompany. To effect conformity with those provisions, a maximum validity of 30 days after the date of its issuance will be given Form 2511. But the maximum period will not be stated on the issued form, as the earliest possible appearance of the applicant is desirable in view of the reservation of a hospital bed.

Form 2511a, Notice to Report for Hospitalization or Domiciliary Care (automobile transportation at Government expense)

Form 2511b, Notice to Report for Hospitalization (ambulance transportation at Government expense).

Form 2515, Notice to Report for Hospitalization or Domiciliary Care (transportation not at Government expense): It is important to specify hospital treatment and delete domiciliary care.

Form 2509, Authorization for Attendant (definite).



Form 2509a, Authorization for Attendant (conditional).

(2) Form 2511a informs the applicant that no garage space is available at the facility. Because of this, travel by automobile, whether personally-owned or rented, will not be authorized unless the facility is informed in advance of issue of the travel notice that the applicant or his representative purposes to use that mode of transportation. With this exception, travel to a facility for hospital treatment will be authorized by common carrier (railroad or bus). Requests for round-trip transportation (if sold by carrier) and meal and lodging requests to cover round-trip travel, will be inclosed with Form 2511, if the issuing officer decides that the period of hospitalization will be ended before expiration of the validity date for return travel. If this decision cannot be made with reasonable assurance, then requests for transportation and meals and lodging needed for one-way travel to the facility will be inclosed; and such requests, to cover return travel upon completion of hospitalization and regular discharge, will be supplied by the facility at which hospitalization had been furnished. However, if an applicant, furnished such transportation, uses an automobile instead, reimbursement for oil and gas or mileage allowance may be made, if he surrenders the common carrier request.

(3) Form 2515 is mailed to the applicant, without transportation requests or tickets, when he has stated on Form P-10 that he is financially able to defray the expense of transportation to the facility (for treatment of a condition not service-connected).

(4) Form 2511b, Authorization for Ambulance Transportation.-- This may be made definite or conditional, dependent upon the fulness and trustworthiness of the information that can be developed by the chief medical officer or clinical director or their designates. A conditional authorization contemplates that determination of the actual need for the ambulance will be made upon arrival of the applicant at the facility. Upon that determination will depend whether the cost of the use of the ambulance will be accepted by the Veterans Administration, or be borne by the patient or his representative. In the latter case reimbursement, in the amount that the travel would cost the Government if it had been made by common carrier, may be made the patient or his representative.

Ambulance travel should rarely be required in ordinary hospital admissions. Its authorization may be considered when the information indicates that it is the only transportation which can safely be used in view of the applicant's condition; or when travel by Pullman or common carrier is not available or, if available, would necessitate long layovers or transfers. Ordinarily, since Pullman travel is more economical and more comfortable for long distance travel, it should be authorized when available, in preference to ambulance.

Since hire of an ambulance usually includes the service of an attendant or stretcher-bearer besides the chauffeur, the routine authorization of an attendant at Government expense will be avoided in these circumstances.

Authorizing officials, including officers of the day, will familiarize themselves with the ambulance contracts which are in effect, and the locations and telephone numbers of the contractors, to prevent necessity for use of non-contract ambulance travel at rates in excess of those stipulated in contracts.

(5) The type of Pullman accommodations desired for a beneficiary must be specifically authorized. Information as to what was so authorized and what was supplied must accompany the vouchers for such service. Accordingly, when reservations (Paragraph 6070 continued.)



for a beneficiary's travel are made in advance by the facility, for a berth, section, drawing room or compartment, the railroad company will be informed whether the beneficiary is ambulant or is a stretcher patient, and whether his reserved bed is to be made up for daytime use. The Pullman Company's tariff provides that "berths, sections or rooms will be made up with beds for use during the day upon payment of the night rate for the accommodations used". The attendant who is to accompany a beneficiary to (or from) a facility will be instructed to supply the foregoing information as to the patient's condition when making reservations; and, in such cases, there will be indicated on the memorandum copies of the transportation requests the exact type of berth, section, drawing room or compartment that was used, and whether the bed was made up for daytime use.

(6) Forms 2509 and 2509a, definite and conditional authorization for an attendant to accompany the incoming applicant, will have only conservative use in ordinary hospital admissions. As much information as possible should be developed as to actual necessity for an attendant in such admissions, before this authorization is issued. A conditional authorization contemplates that it is granted because of statements of the applicant or his representative that an attendant is necessary; that it is to be used on the responsibility of the applicant or representative, subject to final determination when the patient arrives at the facility; that if, at that time, it is medical judgment that the attendant was not necessary, none of the expense therefor, including transportation of the attendant, will be accepted by the Government. A physician-attendant will be authorized only upon particular consideration of the need for a physician's services en route. (See also paragraph 6075.) (February 26, 1943.)

(7) Authorization for an ambulance or an attendant, like authorization for travel, must be issued in advance. But if, without prior authorization, an applicant uses a hired ambulance or an attendant, because of change in his physical condition after issuance of the travel authorization; and the chief medical officer or clinical director determines that either or both such unauthorized items was or were necessary and could properly have been authorized in advance if the condition of the traveler was then known, the chief medical officer or clinical director, through the manager, may recommend that the expense of the ambulance hire, or fee for the attendant, or both, be approved for payment or reimbursement, at Veterans Administration rates. [See subparagraph (8) for reference of claims to the director of finance.

(8) When there had been no advance authorization for the mode of travel that was performed or service rendered, or when the authorization that was issued was incomplete or doubtful in its terms, any recommendation that is made by station officials relative to vouchers or claims pertaining thereto, will be transmitted, with a full statement of the facts, to the director of finance. If there are medical considerations involved, the director of finance will submit the case to the medical director for opinion. When a conditional authorization had been issued, the travel performed or service rendered differed from the terms of the authorization, and the question is whether the medical circumstances were such as justified any greater expense incurred, the medical director is empowered to approve or disapprove the claim. When the circumstances are such that the issuance of prior authorization, or the terms of the authorization, if issued, cannot be clearly established, the medical director may recommend payment, to the director of finance, for consideration by the Administrator.] (April 22, 1944.)



(B) Hospital Observation and Physical Examination - Form 2511, authorizing common carrier transportation and specifying hospitalization for observation and examination, will be used. Form 2511a, authorizing automobile transportation, may be issued under the same conditions as in (A) (2). An attendant may be authorized, by Form 2509 or 2509a, if apparently required: this authority should be conservatively exercised.

(C) Domiciliary Care - Form 2511, for common carrier transportation, should be used if the applicant for domiciliary care has stated on Form P-10 that he is financially unable to defray the expense of the travel to the selected facility. Otherwise, Form 2515 will be issued. Form 2511a, automobile transportation, may be sent the applicant, subject to conditions specified in (A) (2). Ambulance transportation is not in order for an applicant who is to be provided domiciliary care, and an attendant should rarely be required. Round-trip requests or round-trip tickets are not to be inclosed; one-way transportation to the facility is to be supplied.

(D) (1) When, in issuing notice to report for hospital observation, hospital treatment or domiciliary care, it is known that the traveler must use two or more (Paragraph 6070 continued.)







modes of travel, e.g., when he must use a vehicle from his home to the point where he is to begin travel by a common carrier, he is to be supplied necessary requests for the common carrier (railroad or bus or steamship) part of his journey; and, for the travel from his home to the common carrier line, he will be supplied Form 3267, U. S. Government Request for Special Transportation, or be informed that reimbursement will be made for reasonable expense incurred by him in securing transportation for this link in his travel. (See also paragraph 6068.)

(2) When Form 3267, special transportation request, was not issued, either because it was not known that rural travel from the place of residence of the traveler to a common carrier point was necessitated, or because the distance to be so traversed was not known, the traveler may be reimbursed for reasonable expense of such necessary rural transportation, provided such travel was made in an area served by the post office to which the notice to report had been addressed, and further provided that the traveler presents proper receipts for the expenditures. (February 26, 1943.)

See also R. & P. 4175, Finance.

6071. ROUND-TRIP REQUESTS.--(A) When forwarding Form 2511, authorizing travel to a facility for hospital observation or hospital treatment, by common carrier transportation, there will be inclosed transportation, meal and lodging requests (if necessary) for round-trip travel, provided it is estimated by the issuing station that such hospitalization will not exceed in probable duration the period of validity covered by a round-trip fare.

(1) When round-trip transportation is supplied in hospitalization for observation and physical examination, the chief medical officer or his designate of the regional office (including one that is a part of a facility) will enter on Form 2557, Admission Card (the authorization instrument for such hospital admission), and on Form 2511, Notice to the Claimant or Beneficiary to Proceed for Hospital Observation, the notation "(Return Ticket) (Return Transportation Request) furnished." Upon arrival of the traveler at the selected facility, those forms will be scrutinized for such notations, and if they have been recorded, the traveler will be required to surrender the return transportation request or return ticket, and any unused special transportation request or meal or lodging request, subject to return and use when and if the hospital observation is completed and a regular discharge is given him.

(2) In authorizations of admission for hospital treatment, the notation specified in (1) will be entered upon the Form 2511.

(3) If, when return transportation request or return ticket had been supplied the traveler, the time limit for their validity expires before the hospital observation or treatment could be completed, the facility, when the service is terminated and regular discharge is to be given, will supply the claimant or beneficiary with a travel order, Form 2512, and with a transportation request to return him to the point from which he proceeded. The expense of such return transportation will be chargeable to the budget allotment of the discharging facility.

(4) The return ticket may be exchanged for a ticket with the limit desired upon presentation of a transportation request calling for such exchange. In such instances the carrier will render its bill at the difference between the round-trip fare applicable on the transportation originally issued, and the higher round-trip fare applicable for transportation with longer limit.

(5) In the event the return portion of the ticket is not used, the regional office or facility originating its issue will promptly transmit the unused portion of



the ticket to central office with letter of advice, as the redemptive value thereof can be secured from the transportation company. If the station taking up the unused portion of the ticket did not originate its issue, such portion will be returned to the originating station for the action indicated herein.

(B) Since domiciliary care is contemplated for an indefinite duration, and prior consent of the director of national homes is required for the furnishing of return transportation for a beneficiary who is about to be discharged from domiciliation, the furnishing of round-trip requests or tickets is not applicable in such admissions to facilities, and incoming transportation only will be supplied. (February 26, 1943.)

[(C) When it has been ascertained or can reasonably be supposed that a beneficiary who has been transferred from a facility where he was receiving hospital treatment or domiciliary care, to another facility, for special services (such as transfer to a tumor clinic for treatment, or to a diagnostic center for diagnosis, with possible treatment to follow), will not be returned to the transferring facility, one-way instead of round-trip transportation may be furnished.] (December 31, 1943.)

6072. ALTERNATIVES TO SUPPLY OF TRANSPORTATION REQUESTS.--Instead of supplying transportation, meal and lodging requests, the Veterans Administration may, when requested, (A) reimburse the applicant or his representative for approved expenditures for travel, or (B) make mileage allowance, as hereinafter provided. (February 26, 1943.)

6073. REIMBURSEMENT OF EXPENSES INCURRED IN TRAVEL FOR HOSPITALIZATION OR DOMICILIARY CARE.--(A) Ambulance transportation - the fee allowed for this will not exceed that authorized in the Schedule of Fees for Medical Services, Veterans Administration. If a smaller fee than allowed under the said schedule had been agreed upon beforehand, it will be specified on Form 2511b.

(B) Automobile Transportation --(1) If the automobile used was one owned by the applicant or his relative, no hire fee will be allowed. Instead, reimbursement may be made, if requested, for actual expense incurred en route, including cost of oil and gasoline consumed over the shortest and usually traveled roads; ferry, bridge or road tolls (except when payment of such tolls is not required of persons traveling on Government business); and actually necessitated garage or parking fees. Receipts for any and all such expenditures (except meals) must be procured by the traveler or representative (which may include a relative, guardian, a local physician, a Red Cross worker, or an officer of an ex-service men's organization), and be submitted to support the voucher. The total reimbursement for any such expenditures cannot exceed the cost of transportation and necessary meals that would have been incurred had the travel been made by common carrier.

(2) If the automobile had been hired, a reasonable fee - commensurate with the usual charge prevailing in the community - may be allowed; provided that the travel was over the shortest and usually traveled roads; that it does not exceed the cost of travel (plus necessary meals) by common carrier for the distance; that the owner or driver certifies on his bill that, at the time of the travel, the fare charged was that prevailing in the community; and further certifies that the car used was not, at the time of the travel, the property of the beneficiary or a relative of the beneficiary. A relative, for this purpose, will be a wife, a son or daughter, a father or mother, or a brother or sister. (February 26, 1943.)

[(C)] Common Carrier Transportation.--(1) For transportation by common carrier, reimbursement can be made as follows: by railroad, cost of fare, necessary meals, and Pullman accommodation if used; by bus, cost of fare, necessary meals en route, and



lodging if used; by boat, cost of fare, necessary meals, and stateroom lodging, if not included in the fare. Receipts for such expenditures must be submitted to support the voucher. When transportation requests had been issued, but were not used, reimbursement cannot exceed the total expense that would have been incurred had the requests been used.

(2) For meals and lodging needed in completion of travel, reimbursement, if requested, may be made in amounts not to exceed \$6.00 for 24 hours; not to exceed \$1.25 for a single meal; and not to exceed \$2.25 for a single lodging. When meals and lodging requests had been issued but were not used, reimbursement for meals and lodging will not exceed what would have been incurred had the requests been used. (See also R. & P. 8421, Supply.)

(3) For expense of wheel chair or stretcher, or taxicab or ambulance transportation, or checking of baggage necessitated in train transfers, see R. & P. 4433 (B).

(D) Specific prior authorization is required as a condition precedent to reimbursement for use of an ambulance or hired automobile and cost of meals necessary en route to a total amount in excess of the expense, including probable cost of meals, that would be involved had the beneficiary and an attendant (if used) traveled the same distance by common carrier. See R. & P. 6070 (A)(7) as to emergency travel necessitated by change in physical condition. (December 31, 1943.)

(E) Vouchers covering fee for attendant service will be accompanied by a certification, signed by the payee, that he is not a relative of the beneficiary whom he accompanied. In instructing prospective payees of this requirement, the definition of a "relative" for this purpose will be communicated. (See R. & P. 6075 (B).)

(F) If travel be performed from a point other than authorized in the travel order, reimbursement therefor will be limited to an amount not exceeding the cost that would have been incurred in travel from the city or town authorized.

(G) Reimbursement for any expense of travel incurred after expiration of the 30-days maximum validity date of the authorization for travel (see R. & P. 6070 (A)(1)) will not be granted unless a request for extension of that validity period had been made by the traveler or representative, with sufficient reasons for the request, and that request had been approved. If an applicant fails to report at the selected facility within the validity period aforesaid, and there has been no extension granted, the finance officer will promptly be informed, so that he may cancel the encumbrance.

(H) The finance officer will promptly be informed of all authorizations of travel and other expense incident to facility admissions, so that he may effect encumbrances on his allotment ledgers. (R. & P. 4167.) (February 26, 1943.)

(I) Vouchers covering claims for reimbursement of transportation and other expenses incident thereto, will be prepared and paid at the facility which authorized the travel, except that claims of a doubtful character, and those submitted by administrators of estates of deceased beneficiaries or by heirs, involving expenses incurred by the beneficiary from his personal funds, will be forwarded to the director of finance. [(See R. & P. 6070 (A)(8) for reference of claims to the director of finance.)] (April 22, 1944.)

(J) Subject to the foregoing conditions, reimbursement may be made to a person other than the beneficiary, or to an organization whose funds, it is shown, were used to defray the expenses involved. Receipts of vendors, made out to the person or organization that bore the expense, will be acceptable evidence in support of a claim for reimbursement for transportation and other expenses, when submitted by such person or organization. When such other person or organization had advanced cash to the beneficiary, which he had expended for authorized transportation, etc., such other person or organization, in claiming reimbursement, must submit receipts of the bene-



ficiary for the cash advanced him, together with receipts for each item of his travel expenses paid out of the sum so advanced, including meals en route, obtained by the beneficiary from the vendors. Waiver to all payments in favor of the person or organization will be required from the traveler, as provided in R. & P. 4430.

(K) Reimbursement claims must be presented on the prescribed voucher form, supported by the original travel order or certified copy thereof, and by properly executed receipts for the expenses claimed.

(L) If a patient dies before requesting reimbursement for travel expense, inquiry may be made whether such claim will be submitted. If so, assistance will be given the person desiring to make claim. When some person or organization had supplied cash to the dead patient, with which he had procured transportation, such person or organization must look to the patient's representative for receipts of cash so advanced or receipts for travel expense (meals, etc.,) that had been procured out of the cash advanced. In such circumstances, the claim must be supported by a statement from someone (other than the party submitting the claim), having actual knowledge of the facts, that the money expended by the patient was furnished for his use by the maker of the claim. This procedure, as related to a deceased beneficiary, will be also applicable to one who becomes mentally incompetent during hospitalization and before claiming reimbursement of travel expenses. (February 26, 1943.)

6074. MILEAGE ALLOWANCE.--Pursuant to the provisions of Executive Order No. 8454, June 26, 1940, payment may be made to claimants or beneficiaries, and to their authorized attendants (not in the regular employment of the Veterans Administration), of a mileage allowance in lieu of actual and necessary expenses of transportation and of meals and lodging incident thereto, necessary to accomplish travel to a facility for hospital observation, hospital treatment or domiciliary care. Such mileage allowance will be computed upon the distance traversed or to be traversed under prior authorization for the travel.

(A) Rates of allowance - For not to exceed 100 miles,  $1\frac{3}{4}$  cents per mile; for more than 100, but not to exceed 400, 2 cents per mile; for more than 400,  $2\frac{1}{2}$  cents per mile. These distances are applicable only to continuous travel. Authorized travel to and from a place shall be considered continuous travel when the physical examination or treatment of the claimant or beneficiary, or the duties of his attendant, if any, at the station where such service was rendered, had been completed on the day of arrival, and a regular discharge had been given.

(B) Grant of Allowances - (1) Authorizations for travel will not be issued on a mileage basis; but, when travel has been performed, there may be granted a mileage allowance, when requested in lieu of reimbursement of expense of authorized travel to a facility, when the traveler has obtained no subsistence, lodging or transportation through use of Government requests, tickets, or tokens; and has neither used any Government-owned conveyance nor received any meals or lodging at Government expense, nor incurred any expenses that might be presented as charges against the Veterans Administration for transportation, meal or lodging in connection with authorized travel.

(2) An authorized attendant (other than a person in the regular employment of the Veterans Administration) may be granted mileage allowance under the same conditions in (1) applicable to the traveling claimant or beneficiary.

(3) Persons claiming mileage allowance are not required to show either the mode of their transportation nor any of the expenses thereof, in submitting their schedule of travel with claim for mileage. Payment for mileage is not based upon comparative cost of common carrier travel for the distance, but upon the mileage (and not to exceed the mileage) that would be covered by automobile travel upon the



most direct and usually-traveled highways between the designated points, as shown by recognized, authentic highway maps.

(4) Following completion of and regular discharge from hospital treatment, or out-patient examination or treatment, or when the director of national homes has authorized return transportation for a member who is to be discharged from domiciliary care, mileage allowance, to cover return travel to the place to which any such claimant or beneficiary is entitled to return at Government expense, may be paid in lieu of the supplying of common carrier transportation or the reimbursement of actual necessary expenses for return travel, under the same conditions stated in (B) (1) of this paragraph and subject to the surrender of any requests or tickets that had previously been supplied for return travel. Should he so elect mileage, a voucher will be prepared, supported by the travel order originally issued; and when that voucher is received by the finance officer, and before it is sent, approved, to the agent cashier or disbursing officer, for payment, the encumbrance will be set up under symbol 0270, upon the basis of the amount approved on the voucher. The encumbrances originally set up under symbols 0250 and 0280, when the travel order was issued, will be liquidated in the usual manner, but this action will have no bearing upon the encumbrance under symbol 0270.

(C) Expression of Election for Allowance - (1) This, to be entered upon the reverse of the original, or upon a certified true copy of the travel authorization (that is, notice to report) used to support the beneficiary's reimbursement claim (voucher), will read:

Having obtained no subsistence, lodgings or transportation through the use of Government requests, tickets or tokens, and having neither used any Government-owned conveyance nor received any meals or lodging at Government expense, nor incurred any expenses which may be presented as charges against the Veterans Administration, for transportation, meals or lodging in connection with my authorized travel from \_\_\_\_\_ to \_\_\_\_\_ and \_\_\_\_\_, and with the understanding that no part of the actual and direct expenses for transportation, subsistence and lodgings in connection with the uncompleted portion of my authorized travel is to be borne by the Veterans Administration, I hereby elect to claim mileage allowance in lieu of actual expenses of travel for this entire trip.

(2) A copy of such written election will also be placed on the reverse of the copy of the travel authorization used to support the first copy of the reimbursement (voucher) claim. Only the statement of election on the original or certified true copy of the travel authorization need be signed by the traveler.

(3) Election to claim mileage allowance will not be recognized when reimbursement for any part of actual expense of the authorized trip is claimed by the traveler.

(4) The "meals or lodging" mentioned in this written expression of election for mileage allowance refers to any meals or lodging the claimant had while en route. Such meals or lodging as are supplied to a person held over for completion of an out-patient examination are wholly distinct from meals and lodging necessary in travel, and have no relation to a claim for mileage allowance.

(D) Form Used for Allowance Claim - (1) Standard Forms 1012 series (exclusive of Form 1012e) will be used in making claims for mileage allowance. These forms will be prepared in triplicate (original of 1012, two copies of 1012a) and will be supported by copies of written travel authorizations.

(Paragraph 6074 cont'd.)



(2) In addition to the completed face sheet of the voucher (Forms 1012 and 1012a), the reverse side will be used for the listing of surrendered transportation, meal and lodging requests, if any, and the supply personnel's acknowledgment of receipt of any such unused requests, tickets or tokens. If no requests have been issued, this fact will be stated.

(3) The inside portion of the forms will be used to detail the traveler's claim, in accordance with following exhibits. No cash payments of mileage allowance will be made at those field stations which do not have a finance officer on the premises, and no cash payments will be made to attendants or beneficiaries outside of prescribed office hours. Neither beneficiaries nor attendants will be permitted to remain over meal hours or overnight, etc., at field stations at any expense to the Government for additional fees or for meals and lodgings at a facility or elsewhere, in order that they may be paid mileage allowance in cash.

(E) Payments of mileage allowance will be made only to the beneficiary and attendant (when authorized to travel) who actually performed the travel. No assignments to third parties or waivers of mileage allowance claims in favor of third parties will be recognized. In any case where a bill for transportation charges is received in connection with travel for which mileage allowance has been approved for payment to a beneficiary and/or attendant, such bill will not be approved for payment, but will be submitted to finance service, central office, with a full statement of facts. In cases where Government requests are issued for services to be rendered more than one person, none of the persons on whose account the requests have been issued may be paid mileage allowance unless all of the requests issued for both joint and individual use of the travelers are surrendered for cancelation. In cases involving travel of attendants both the attendant and beneficiary must be reimbursed on the same basis, that is, if either traveler uses or desires to use Government requests, tickets or tokens or Government conveyance or other conveyance for the use of which the Veterans Administration will pay any bills or charges, or if either traveler claims reimbursement for any or all actual expenses of travel, no claim of the companion traveler for mileage allowance may be recognized.

(F) (1) Claims for reimbursement of travel expense on a mileage allowance basis must bear the endorsement of the chief medical officer or clinical director or their designates, or responsible domiciliary officials, to show that the purpose for which the travel was authorized has been fully accomplished; e. g., that the attendant has performed properly the required service, that hospital admission for treatment or for observation and examination, or admission for domiciliary care, had been effected. The day and hour of such admission will be entered upon the reverse of the original or certified true copy of the travel authorization used to support the traveler's reimbursement claim, over the signature of the responsible official. A copy of this endorsement will also appear on the reverse of the copy of the travel authorization used to support the first copy of the reimbursement (voucher) claim.

(2) On the face of all vouchers (Standard Form 1012) claiming reimbursement on mileage allowance basis will be inserted, at the end of the certifying officer's statement and immediately above the signature line, the phrase "Approved under provisions of Executive Order No. 8454, of June 26, 1940."

(G) (1) Budget encumbrances covering the type of reimbursement claim comprehended herein will be recorded under symbol 0270, upon presentation to the finance officer



of a properly certified voucher endorsed to show the return, unused, of all transportation requests, regular or special, and meal and lodging requests which had been issued.

(2) Liquidation of encumbrances covering such requests will be upon the basis of value at time of issue, and upon the written request of the issuing official (supply officer).

(H) An attendant authorized to accompany a beneficiary traveling to a facility, may claim and be paid mileage allowance, at prescribed rates, for incoming travel and his return travel to the point from which he proceeded. If he has been authorized a fee for the service, that too can be paid to cover time consumed by him in incoming travel with the beneficiary; but fee to cover time taken for his return travel can be paid only upon its proper completion.

(I) When a beneficiary or his attendant has elected mileage allowance to cover incoming travel, but has died or become mentally incompetent before he could collect that allowance, payment thereof may be approved in favor of the person legally entitled thereto.

#### EXHIBIT NO. 1

Sample schedule for one-way travel of beneficiary for hospitalization or domiciliary care:

#### MILEAGE ALLOWANCE PAYABLE IN CASH OR BY CHECK AFTER ADMISSION

Date	Character of Expenditure	Amount
1942		
Aug. 1	Left residence, 8 miles north of Laramie, Wyo., on Route US 30, at 7:00 a.m.	
Aug. 1	Arrived V.A.F., Cheyenne, Wyo., 9:30 a.m.	

Distance traveled, 60 miles

Mileage claimed, 60 miles @ 1-3/4¢ = \$1.05

Note: For travel for similar purposes to a facility other than one under direct and exclusive jurisdiction of the Veterans Administration, mileage allowance is payable only by check upon completion of travel.



## EXHIBIT NO. 2

Sample schedule for round-trip travel of attendant in connection with hospitalization or domiciliation of a beneficiary:

### MILEAGE ALLOWANCE AND FEE PAYABLE IN CASH OR BY CHECK AFTER COMPLETION OF TRAVEL

Date	Character of Expenditure	Amount
1942		
Aug. 1	Left V.A.F., Cheyenne, Wyo., 9:00 a.m.	
Aug. 1	Arrived at home of beneficiary, John Doe, 8 miles north of Laramie, Wyo., on Route US 30, 10:50 a.m.	
Aug. 1	Left home of beneficiary, 11:00 a.m.	
Aug. 1	Arrived V.A.F., Cheyenne, Wyo., with beneficiary for hospitalization, 1:15 p.m.	
	Distance traveled, 120 miles	
	Mileage claimed, 120 miles @ 2¢	2.40
	Fee for services, 4 hrs. 15 min.	2.50

## EXHIBIT NO. 3

Sample schedule for round-trip travel of attendant in connection with hospitalization or domiciliation of a beneficiary:

### MILEAGE ALLOWANCE PAYABLE IN CASH AFTER DELIVERY OF BENEFICIARY TO VETERANS ADMINISTRATION FACILITY

Date	Character of Expenditure	Amount
1942		
Aug. 1	Left residence, Laramie, Wyo., 6:30 a.m.	
Aug. 1	Arrived at residence of beneficiary, John Doe, 8 miles north of Laramie, Wyo., on Route US 30, at 6:45 a.m.	
Aug. 1	Left residence of beneficiary, 7:20 a.m. Arrived V.A.F., Cheyenne, Wyo., with beneficiary for hospitalization, 9:30 a.m.	
	Distance traveled, 68 miles	
	Distance to be traveled on return trip, 52 miles	
	Mileage claimed, 120 miles @ 2¢	2.40
	Claim for authorized fee to be presented upon completion of travel.	

Note: Claim in connection with travel for similar purpose, including claim for attendant's fee, may be paid by check upon completion of travel, in which event the schedule of travel will be completed to show time of departure from facility and time of arrival at residence.] (February 26, 1943.)



6075. ATTENDANTS - (A) Authority to employ. - An attendant or attendants, to accompany a claimant or beneficiary who is traveling to a facility for hospitalization, may be authorized when, in the judgment of a chief medical officer, clinical director or their designates, such attendance is necessitated because of the physical or mental condition of the claimant or beneficiary. (See Railroad Travel Precautions Relative to Psychotic or Tuberculous Beneficiaries.) (February 26, 1943.)

(B) Persons not in the regular civilian employment of the Government.--(1) These may be authorized to act as attendants and, while so employed, will be furnished common-carrier transportation, meal and lodging requests. In addition they will be paid a fee, as hereinafter provided, except when they are relatives of the claimant or beneficiary. A relative, for this purpose, will comprehend a spouse, parent, son or daughter, brother or sister, uncle or aunt, niece or nephew, by blood or marriage. Payees will be required to certify, in support of vouchers covering [fee as attendant], that they are not a relative, as thus defined, of the traveling claimant or beneficiary. Claims for reimbursement of actual expenses incurred by such attendants for meals and lodging en route will not be certified for payment unless (as in emergency admissions), meal and lodging requests had not been issued, or, if issued, were surrendered for cancelation, with satisfactory explanation why they were not used. That explanation, in brief, will accompany the reimbursement voucher when it is approved for payment. (See R. & P. 6073 (C) (2) for rates of reimbursement.) For return travel, in lieu of being furnished transportation, meal and lodging requests or common carrier tickets, or of being reimbursed for expenses incurred, such attendants may be granted mileage allowance, as provided in R. & P. 6074, plus computed fee, if fee be allowable as provided. Unused requests must, however, first be surrendered. (December 31, 1943.)

(2) The issuance to a nonemployee-attendant (for travel that is to continue approximately 24 hours) of three meal requests (breakfast, luncheon, dinner or supper) and a lodging request, while customary, need not be invariable. When such attendants have to travel an entire night or the greater part of one, a meal at midnight or early thereafter may be required, either with or without lodging, since these attendants are expected to be awake, alert, and attentive to the needs of the traveling patient. Accordingly, there may be issued such attendants, meal and lodging requests for use during such portion (whether day or night) of a 24-hour period, as the circumstances and hours of travel make appropriate. Reimbursement can be allowed for such requests as are not used by these attendants, provided that the amount reimbursed will not exceed the value of the requests, and that the maximum rates authorized under R. & P. 6073 (C) (2) are observed.

(C) (1) Persons in the regular civilian employment of the Government.--These, including employees of the Veterans Administration (subject to the conditions specified in (D)) may be authorized to act as attendants and, when so assigned, will be entitled to transportation and expenses incident thereto. They may be allowed per diem in lieu of subsistence in accordance with the provisions of Standardized Government Travel Regulations, upon issuance of authorization therefor, and will not be supplied meal and lodging requests. No fee will be paid such attendants. Such persons, when assigned as an attendant, may be authorized to transport the beneficiary in an automobile which is privately owned, and in such cases the attendant may be authorized to perform the travel on a not to exceed five cents a mile allowance basis, in accordance with Standardized Government Travel Regulations.



(2) An employee acting as authorized attendant to a beneficiary may not be paid per diem allowance for travel performed between the hours of 8:00 a.m. and 6:00 p.m. when his regular tour of duty falls within those hours; when the employee's regular tour of duty for the calendar day involved is other than between 8:00 a.m. and 6:00 p.m., he may not be paid per diem for travel performed entirely within the hours comprising his regular tour of duty. Attendants performing authorized travel as above, who are on a subsistence basis under contracts of employment, may be reimbursed to the value of meals missed while accomplishing such travel. In inter-facility transfers, the referring station will supply the employee-attendant accompanying the transferred patient with a memorandum to the manager of the receiving facility, stating that the attendant is in duty status and entitled to subsistence as a part of his employment contract. That memorandum will be authorization to supply the necessary meal or meals. (See also R. & P. 9292 (J).) Chauffeurs, not being on a subsistence basis, will not be supplied meals as provided herein.

(D) Employees of the Veterans Administration will not be detailed as attendants if such assignment will interfere with their regular duties. In no case will an administrative officer, or technical or other highly trained personnel (other than physicians or nurses) be detailed for such service; and physicians or nurses will be assigned to it only when, in the careful judgment of the chief medical officer or clinical director, ordinary attendant service will not be adequate, but the traveling patient will require medical or nursing attention en route. (February 26, 1943.)

(E) When proposed travel of a beneficiary is not at Government expense (e.g., [in an inter-facility transfer, trial visit, leave of absence, recreational outing]); the beneficiary, his guardian or representative requests assignment of a trained attendant of the Veterans Administration; the services of such employee can be spared for the time necessary, and he is entitled to sufficient annual leave to cover, application for such leave by such attendant may be granted. [All] other arrangements will rest between the beneficiary, his guardian or representative and such attendant, and the Veterans Administration will bear no expense of nor be responsible for the arrangements. (December 31, 1943.)

(F) Employee-attendants who accompany mentally incompetent beneficiaries being sent from a facility to appear in a court of jurisdiction in insanity proceedings will not be granted official leave unless the chief attorney advises that the court and other expenses incident to the proceedings are to be borne by the Veterans Administration. Annual leave may be granted employee-attendants in cases in which the costs are not authorized by the chief attorney; if they have no accrual of such leave, leave without pay will be authorized for the necessary period. (April 20, 1943.)

(G) The proper selection of an attendant to accompany a traveling beneficiary of the Veterans Administration requires regard not only to his physical vigor, but to his personality and his experience and fitness in general to perform a responsible duty. (February 26, 1943.)

(H) Fees for Attendant Service.--(1) A maximum of \$5.00 for 24 hours; \$2.50 for the first six hours or fraction thereof; \$1.25 for the next six hours or fraction thereof, up to twelve hours; \$3.75 for exactly twelve hours; and \$5.00 for any period beyond twelve hours and up to twenty-four hours. For service in excess of twenty-four hours, the same fractional rates will apply. Less than maximum fees will be authorized if satisfactory service at lower rates can be had in the community. [The basic



fee to be paid an attendant will always be clearly stipulated in advance of his travel, to accord with a Comptroller's Decision (B-9986, May 18, 1940). Should such fee have not been so specified, payment for the service will be in accordance with the Schedule of Fees, Veterans Administration. See 6070 (A)(7) for authorization of use of an attendant when, upon arrival of the patient at a facility, a medical determination is made that an attendant, not previously authorized, was needed.] (December 31, 1943.)

(2) A private physician employed as a physician-attendant may be allowed not to exceed \$10 for twenty-four hours service; \$5.00 for the first six hours or any fraction thereof; \$2.50 for the next six hours or fraction thereof, up to twelve hours; \$7.50 for exactly twelve hours; and \$10 for any period beyond twelve and up to twenty-four hours. For services in excess of twenty-four hours, the same fractional rates will apply. Upon specific authority from the medical director, a fee of more than \$10, but not to exceed \$20 for twenty-four hours, with corresponding fractioning of rates for periods less than twenty-four hours, may be paid in exceptional cases to a physician-attendant. In no case will a physician-attendant be employed if an ordinary attendant would suffice; the traveling patient must require professional attention en route before authorization of a physician-attendant is considered.

(3) The fee for an attendant will be computed from the time he reports at the facility for the assignment as directed, and not for any period prior thereto; provided that, in exceptional cases, as determined by the chief medical officer or clinical director concerned, when it is necessary that the attendant travel to a point at which he is to meet the patient (because an attendant could not be secured at that point), his fee may cover the time consumed in proceeding directly and without delay to that meeting point. His accompaniment of the traveling patient having begun, the attendant's fee will cover the time actually needed to complete the travel to the destination, but cannot exceed the time required for travel by available common carrier, unless it is specified in the authorization that, because of the condition of the patient, the travel is to be performed by ambulance or other special conveyance. In the latter event, authorization may be given for payment of an attendant fee on the basis of time actually required for completion of the assignment by the specified mode of conveyance, without consideration of the travel time that would be taken had a common carrier been used. An attendant, after delivery of the patient at the point designated, will (unless instructed to accompany a claimant or beneficiary upon a return trip) be required to complete his return journey without delay, and by the mode of transportation authorized. Vouchers for attendants' travel will convey sufficient information as to the time the attendant began and ended his assignment. (February 26, 1943.)

(I) [A person driving his own automobile in which a beneficiary is being transported may - when it is determined that he can also furnish such attendant service as is actually required in the case - be authorized to act as attendant; and may for such service be paid an attendant's fee, and either mileage allowance or reimbursement of the actual operating expense of his car. A chauffeur cannot, however, be paid mileage allowance unless authorized to serve as an attendant, since mileage allowance is payable only to beneficiaries and authorized attendants.] (December 31, 1943.)

(J) Travel of an attendant (usually a member of the family) to accompany the body of a deceased beneficiary can be authorized. Such attendant may be supplied a request for a first-class ticket for transportation of the corpse, and a request for



a ticket appropriate to the accommodation that is actually to be used by the attendant viz., coach, or Pullman when the Pullman charge is to be paid by the attendant. An intermediate ticket with tourist Pullman accommodation, or a mixed-class ticket with corresponding Pullman accommodations may be supplied when the cost of such ticket and accommodations (plus first-class ticket for the corpse) does not exceed the cost of shipment of the body by express, which is equivalent to two first-class railroad fares.

(K) When the facility has been informed that a certain person will accompany the traveling patient, authorization to serve as attendant is issued to that person by name, but some other person is substituted for reasons developing later at the point of departure, the attendant's fee (and reimbursement for expenses, if incurred, or mileage allowance) may be made to the substituted attendant, subject to the provision that no fee will be paid if such substituted attendant be a relative, as defined, of the patient. (February 26, 1943.)

6076. TRAVEL WITHOUT PRIOR AUTHORIZATION.--(A) An applicant for hospital treatment who, without prior authorization to perform the travel, presents himself at the facility nearest his place of residence, is admitted and remains for completion of treatment and regular discharge, may be supplied return transportation to the point whence he proceeded (if he has stated, Form P-10, that he cannot defray expense of transportation), but will not be reimbursed for the incoming travel.

(B) An applicant who, without prior authorization, presents himself at a facility other than that nearest his place of residence, is admitted thereto, and remains until completion of treatment and regular discharge, will not be reimbursed for expense of travel to such facility; but may be supplied return transportation for a distance equal to that from his place of residence to the nearest facility that would have been suitable for treatment of his condition. (February 26, 1943.)

6077. CLERICAL PREPARATION OF TRAVEL ORDERS, VOUCHERS, ETC.--Travel orders (that is notices to report, see R. & P. 6070), by common carrier or by automobile, may be prepared under the supervision of the chief medical officer or clinical director or their designates, after which they will be routed to the supply officer, for insertion of serial numbers of the requests for transportation, meals and lodging; or the travel orders may be prepared by the transportation clerk, to conform to the stipulations in a memorandum (station form) from the authorizing official. The transportation clerk will then attach the necessary transportation, meal and lodging requests to cover the travel and will forward the travel order with those attachments to the authorizing official, for his signature before issuance. Orders for travel in an automobile, subject to reimbursement for oil and gasoline, will be submitted to the finance officer, for encumbrance, before release. Reimbursement vouchers will be prepared in the transportation unit under supervision of the supply officer. (See R. & P. 8425, Supply Service; see also R. & P. 6074 (D) as to mileage allowance.) (February 26, 1943.)

6078. EMERGENCY ADMISSION FOR HOSPITAL TREATMENT.--(A) The cardinal consideration in an emergency admission for hospital treatment is the utmost expedition in effecting it. This controlling consideration compels departures from the prescribed procedure pertaining to ordinary admissions. Time is not afforded for the submittal of Form P-10 and definite determination of eligibility under the provisions of R. & P. R-6047 and 6048, or for issuance of the formal notice to report, Form 2511, with inclosure of common carrier transportation request. Requests for emergency admissions will



usually be by telegraph or long-distance telephone, and arrangements as to mode of travel, particularly as to necessity for ambulance transportation, and for attendant or physician-attendant must perforce be guided by such information as can be obtained from the patient or his representative through such media of communication. Automobile transportation has been more often used in emergency than in ordinary admissions. Oral authorizations for use of an ambulance, attendant or physician-attendant, may, if the information developed be unsatisfactory, have to be couched in conditional terms, subject to determination, upon arrival of the patient that his condition is, in fact, emergent and required such precautions.

(B) For the purposes of hospitalization, a medical emergency will be understood as the unforeseen development of an acute condition which will not permit of (Paragraph 6078 Continued.)







out-patient attention (if service-connected), and which requires the earliest possible hospitalization to safeguard the life of the applicant. Emergency hospitalization will not be in order for operations of choice or interval operations, chronic inflammatory processes of the nose, throat, eyes or other organs or parts, dental prosthesis, chronic joint conditions, etc. An emergency will be held to exist in pulmonary tuberculosis when any of the following symptoms are exhibited: hemorrhage (determined as pulmonary), particularly when brisk and profuse; spontaneous pneumothorax; overdue refills in artificial pneumothorax; clear exhaustion symptoms following upon undue exertion; intercurrent pneumonic process; marked toxic reaction, manifested by rapid resting pulse, increased temperature, evidences of prostration and other constitutional symptoms.

(C) Procedure - (1) Upon receipt of a request for emergency hospital admission for treatment, the authorizing officer's immediate considerations will be these:

a. Is the request the first of its kind, or had the applicant been previously (and recently, that is, within six months) hospitalized or domiciled by the Veterans Administration?

b. If he had so previously received hospitalization or domiciliary care, had he been regularly discharged therefrom?

c. If the request is the first of its kind, is there prima facie evidence of the applicant's eligibility under R. & P. R-6047?

d. Is he requesting hospital treatment for a disease or injury adjudicated as service-connected, or for a condition not attributable to former military or naval service?

e. What is the relative acuteness of the emergency as related to the mode of transportation that is to be authorized? Will an ambulance be necessitated or an attendant, or a physician-attendant?

(2) Those informative data will be developed from the applicant or his representative as far as possible, and by consultation of such records (the applicant's C-file, or treatment (out-patient) file) that may be in possession of the facility. If the request was telegraphic, time will be afforded for consultation of such records, before the reply telegram of authorization is prepared and sent. If such records show patent ineligibility (that is, some flaw as to military or naval service, character of discharge, etc.), the applicant or representative will be so informed. If there is a Form 2593, Record of Hospitalization or Domiciliary Care, in the case file showing an irregular facility discharge not yet cleared by expiration of a period of exclusion that had been imposed as a penalty, the applicant or his representative will be informed that, although rehospitization for an actual emergency is authorized, the expense of all transportation to the facility (including attendant, if used) must be borne by the applicant. If the authorizing office is told that the applicant or his representative cannot defray such expense, he will clearly put the applicant or representative on notice that upon arrival that statement will have to be confirmed under oath. Transportation to effect admission may then be authorized, subject to this understanding.

(3) If the request is the first of its kind, and is for treatment of a service-connected disease or injury, transportation is authorizable. But if, though the first of its kind, the request is for treatment of a disease or injury not attributable to military or naval service, the applicant will be asked whether he can defray the expense of transportation. If the request is for rehospitization and (Paragraph 6078 cont'd.)



the applicant has an uncleared disciplinary status, he will be put on notice that he must defray the expense of the travel, even if he requires treatment for a service-connected condition; unless inability to defray such expense is stated and is confirmed by execution of an affidavit.

(4) If the contacted facility has no such records in its possession; or, if in possession of them, they are not readily accessible, (in requests by long-distance telephone), then the definite assurance of the applicant or his representative that the applicant is an ex-member of the armed forces; that he was not dishonorably discharged from previous military or naval service; that he was not irregularly discharged from a facility of the Veterans Administration within the past half year; and that he can or cannot defray the expense of travel to the facility (for treatment of a nonservice-connected condition) can be accepted. The informant will, however, be told that such representations are provisionally accepted, subject to definitive determination of complete eligibility of the applicant when, after arrival, he executes his Form P-10.

(5) If the applicant is in a disciplinary status, and transportation to the facility has been supplied after he or his representative has declared inability to defray such expense, the applicant's answer to question 10, Form P-10, will suffice as a sworn statement, and it will not be necessary to execute a separate affidavit, as provided in R. & P. 6079.

(6) If, after admission, the applicant is definitely determined not eligible for hospital treatment, he will be discharged as soon as the emergency has ended and he can travel with safety. No return transportation will be then supplied; and the patient will be billed at the rate of \$3.75 per diem for each day of such treatment, plus cost of transportation, including attendant if used.

(7) If a patient admitted in an emergency dies before Form P-10 could be executed, and answer to question 10, that form, relative to inability to defray expense of transportation could not thus be obtained, the surviving spouse or other nearest relative, if there be no spouse, will be requested to execute the Form P-10. If, however, such incoming patient had been accompanied by a representative, the latter can execute Form P-10 before leaving the facility.

(D) Whatever arrangements are approved by the authorizing officer must be clearly stipulated to the applicant or representative, particularly as to mode of travel, especially if by ambulance, and accompaniment of an attendant. If the authorizations are conditional, the consequences that will follow the determinations as to the patient's condition upon arrival at the facility will be explained, viz., that, if no medical emergency be then evident, he will not necessarily be admitted, nor will return transportation be necessarily supplied; and that the expense of any extra items of the incoming travel, e.g., ambulance or attendant, having been found not actually needed, may be the responsibility of the applicant or his representative. (See R. & P. 6070 (A)(4).) It is to be kept in mind that what may have been an actual emergency at the time telephonic or telegraphic arrangements for the admission of the applicant had been made and authorization for ambulance transportation and an attendant had been given, may have changed its clinical character upon the arrival of the patient. An instance would be the passage en route of a calculus which had been causing severe renal colic, etc. The good faith of the applicant or his representative cannot justly be impugned in such instances, and arbitrary rejection of the expense of the transportation would not be in order in such circumstances. Vice versa, there may be cases in which



ambulance transportation or an attendant, used without prior authorization, are determined to have actually been necessitated by the acute condition of the patient upon his arrival. [(See R. & P. 6070 (A)(8), for reference of claims to director of finance.)] (April 22, 1944.)

(E) Telephoned authorizations will be recorded in summary (one copy), as promptly as possible after their issuance. The authorizing physician will accurately set down each item of the arrangements made -- that is, mode of travel, use of attendant or physician-attendant, if any, etc., and will state which of the authorizations were unqualified and which were conditional. From this summary will be prepared the confirmatory formal authorizations (Forms 2511, 2511a, 2511b, 2509, 2509a (see R. & P. 6070)) in triplicate, and these must agree in every particular with the telephoned stipulations. Upon these authorizations will be recorded an estimate, under the symbol allotments, of the expense anticipated. These triplicate authorizations will be forwarded without delay to the finance officer, who will set up corresponding encumbrances on his allotment ledger, will retain the original and return the two copies to the authorizing physician, who will keep them for later attachment to the voucher to be submitted to the finance officer. The summary of the telephoned authorization will be held by the authorizing physician until the vouchers in the case have been paid, whereupon it may be destroyed. (See also R. & P. 4175, Finance.)

(F) Telegram authorizations for emergency hospital admissions will be prepared in quintuple. Stipulations as to mode of travel and departure point; fee for attendant, if authorized; reimbursement or payment for hire of ambulance or automobile; and whether any of such authorizations are conditional or unqualified, will be incorporated. The original telegram will be sent to the telegraph company. The four copies will without delay be forwarded to the finance officer for encumbrance, with estimate of the anticipated expense recorded thereon. The finance officer will retain two copies, and will return the remaining two copies to the authorizing officer, for attachment to the voucher when it is received.

(G) When an applicant for emergency hospitalization or his representative states that he is without funds to cover expense of travel to a facility, subject to reimbursement after arrival there, the chief medical officer, clinical director or their designates at the contacted facility may adopt one of two courses of procedure. (1) They may supply round-trip ticket or transportation, meal and lodging requests to cover the travel of the applicant and attendant (if authorized), by special delivery mail, and notify the applicant, accordingly, by telegram; or (2) if it is judged that the emergency is too urgent for that procedure, they may telephone or telegraph the manager of a regional office -- if there be such station in the city or vicinity of the applicant's place of residence -- asking that the regional office supply the applicant and attendant (if authorized) with round-trip transportation and meal and lodging requests, common carrier and Pullman, if available, to cover the travel to the facility (see R. & P. 6066 (B) (3)). The expense of transportation so supplied will be an encumbrance against the station that issues it.

(H) When an applicant for emergency hospitalization contacts a regional office, should a request for emergency hospitalization be made directly upon a regional office, the chief medical officer or his designate in that office, will be concerned with the same considerations specified in (C)(1) hereof.



(1) If the disease or injury for which the applicant needs emergency hospitalization is service-connected, and he is not in a disciplinary status, travel at the expense of the Veterans Administration is to be authorized. If his condition be so relatively urgent that longer travel to a facility under direct and exclusive jurisdiction of the Veterans Administration is inadvisable, the regional office may authorize admission to another Government hospital allocated, or to a civilian hospital, if such be nearer, and the necessary transportation will be supplied by the regional office. If the circumstances otherwise be the same, but the applicant's condition allows of travel to a facility under direct and exclusive jurisdiction of the Veterans Administration, the remaining consideration is whether he has funds to cover travel to the nearest such facility (including expense of attendant, if authorized), subject to reimbursement or mileage allowance upon his arrival at that facility. If he is without such funds, the regional office, as provided in (G)(2), will supply round-trip transportation and encumber its budget in the necessary amount.

(2) If the applicant's condition requiring emergency hospitalization is service-connected, but he is in disciplinary status, he will be required to defray the expense of his travel to such hospital as is selected by the regional office; provided that if he alleges inability to defray such expense (including attendant, if used), he can be supplied round-trip transportation, if he makes sworn answer to question 10, Form P-10, that he cannot defray the expense.

(3) If the disease or injury for which the applicant requires emergency hospitalization is not connected with service, and he is not in disciplinary status, travel to a hospital can be authorized with round-trip transportation at Government expense, if he states that he is unable to defray the expense thereof (question 10, Form P-10). If such applicant's condition be too urgent to permit of his longer travel to a facility under direct and exclusive jurisdiction of the Veterans Administration, another Government hospital allocated to the regional office can be chosen, and the regional office will authorize such admission and furnish the transportation. If a facility under direct and exclusive jurisdiction of the Veterans Administration is selected by the regional office, such applicant will be supplied round-trip transportation thereto by the regional office, with encumbrance of its budget therefor.

(4) If the circumstances be the same as in (3), but the applicant is in disciplinary status, his sworn answer to question 10, Form P-10, that he cannot defray the transportation expense, will serve as an affidavit in lieu of that provided in R. & P. 6079.

(5) Whenever a regional office is sending an applicant for emergency hospital admission to a facility under direct and exclusive jurisdiction of the Veterans Administration, the manager of the receiving facility will promptly be informed by telegram or telephone of the action. Whether round-trip transportation had been furnished, or the applicant directed to defray his travel expense and claim reimbursement or mileage allowance; whether the applicant is in disciplinary status, had alleged inability to defray transportation expense, and had or had not executed Form P-10, including answer to question 10 thereof; and the estimated time of his arrival at the facility, will be items of that information. (February 26, 1943.)

6079. AFFIDAVIT OF INABILITY TO DEFRAY EXPENSE OF TRANSPORTATION INCIDENT TO HOSPITALIZATION.--(A) This will be prepared upon a mimeographed station form which will bear, at its top, the penal provisions of section 15, Title 1, Public No. 2, as they appear at the top of Form P-10, Application for Hospital Treatment or Domiciliary Care. The remaining content of the form will be as follows:



After \*(having read)(having had read to me) the terms of law providing the penalty for false or fraudulent affidavit, I hereby certify that I am financially unable to defray the expense of my transportation from \_\_\_\_\_ to \_\_\_\_\_

(Point of Departure) \_\_\_\_\_ (Destination)

Witnesses to signature by mark (X) \_\_\_\_\_

(Signature of Applicant or Representative)

1. \_\_\_\_\_

(Signature) \_\_\_\_\_ Post Office

Address \_\_\_\_\_

(Number) \_\_\_\_\_ (Street)

(Address)

2. \_\_\_\_\_

(Signature) \_\_\_\_\_

(City) \_\_\_\_\_ (State)

(Address)

Subscribed and sworn to before me this \_\_\_ day of \_\_\_ 19\_\_\_  
by \_\_\_\_\_, to whom the statements herein were fully made  
known and explained. I certify that the questions and answers thereto  
have, in my presence, been (read to)\* the affiant.

(read by)

\*Strike out inapplicable \_\_\_\_\_

words or phrases

(Signature of Person Administering Oath).

(B) The oath may be administered by a notary public, or by an employee under the authority vested with Form 4505.

(C) If a claimant or beneficiary is being readmitted for hospital observation and physical examination after having been irregularly discharged from a previous and uncompleted episode of hospitalization for the same purpose, he will not be entitled to transportation to cover travel necessary for such rehospitalization, unless he alleges inability to defray such expense. In such event, he will be required to execute this affidavit before the regional office (or facility with regional office) supplies the transportation (round-trip ticket or round-trip requests). The affidavit so executed will be kept in the regional office for a period not to exceed one year, at the termination of which it will be recommended for disposition as an inactive record.

(D) In readmissions for emergency hospital treatment of an applicant who is in disciplinary status because of an irregular discharge from a previous episode of hospitalization or domiciliation, transportation must be at the expense of the applicant unless he alleges inability to defray it. In such cases, the applicant's sworn answer to question 10, Form P-10, which is to be executed as soon as possible after an emergency admission, will suffice, and it will not be necessary to execute the separate affidavit specified in (A).

(E) The execution of this affidavit will be required in out-patient activities when a claimant or beneficiary, because of obstruction or refusal of physical examination in a regional office, has lost eligibility for the furnishing of transportation, either incident to his return home, or incident to subsequent travel to the station



for resumption of the interrupted examination. An affidavit executed in these circumstances will be retained in the regional office concerned, and disposed of as provided in (C).] (February 26, 1943.)

6080. [REQUESTS UPON COMMON CARRIER FOR REDUCED RATES - SEE R. & P. 8490, SUPPLY.]

[6081. TRANSPORTATION OUTSIDE THE CONTINENTAL UNITED STATES.-(A) Transportation will not be supplied to effect hospitalization or domiciliary care within the continental limits of the United States of applicants therefor who are residents of foreign countries, or of territories and insular possessions of the United States: except that when contract hospitalization cannot be arranged for an entitled applicant in Alaska, or when the condition of an Alaskan applicant will need such prolonged treatment that it would be more economical to bring him to the continental United States than to authorize his contract hospitalization in Alaska, he can be supplied transportation, provided he states (question 10, Form P-10) that he cannot defray the expense of travel to the United States (for treatment of a condition not attributed to military or naval service).

(B) When travel of a beneficiary is via the Alaska railroad and an overnight stop is made at Curry, \$3.00 may be allowed for lodging and a maximum of \$1.50 for each meal. But allowance for meals and lodging will not exceed \$6.50 for a stopover of 24 hours, unless delay beyond 24 hours is clearly shown to have been unavoidable.] (February 26, 1943.)

6082. [FACILITY VEHICLES.--(A) See R. & P. 6068. The zone of use of station cars, particularly ambulances, is appropriately local, having in mind the necessity of being prepared to answer emergency calls. Essentially, facility vehicles are for use in transporting claimants or beneficiaries to and from common carrier junctions, or for bringing in emergently ill beneficiaries from the neighboring community. Adherence to this principle is particularly in order during the duration, due to necessary conservation of tires and automotive equipment. Accordingly, in emergency hospital admissions, authorization for use of commercial ambulances should in general be preferred to employment of the station ambulance, for distances beyond a local zone. And, in interfacility transfers, common carrier transportation should be used as a rule, unless there are special and urgent reasons for use of a station vehicle, such as inadequate accommodations on common carriers for proper transportation of the patient, or when decided economy and convenience can be served by use of a station vehicle.

(B) Except in emergencies, or in trips on or near the facility reservation, the chauffeur of a facility ambulance or other vehicle will report to the chief, reception and out-patient unit (or, in his absence, to the officer of the day) before departing to transport incoming patients. Upon return to the facility the chauffeur will execute Form 1281, Trip Records of Service Car, for the utility officer; and will not then be required to report to the chief, out-patient unit, or officer of the day unless something unusual has occurred, such as failure to locate the prospective patient, accident to or elopement of patient en route, etc.] (February 26, 1943.)

FOR TRANSPORTATION IN FACILITY DISCHARGES AND TRANSFERS, AND IN OUT-PATIENT SERVICES, SEE PROCEDURE ON THOSE SUBJECTS.



## PREPARATION AND DISTRIBUTION OF FORMS USED IN HOSPITALIZATION AND DOMICILIATION

6087. [FORMS USED IN PROVIDING HOSPITALIZATION OR DOMICILIATION. - (See R. & P. 6062, forms used in authorizing admission for hospitalization or domiciliation; and R. & P. 6070, forms used in directing travel in admissions for hospital treatment or domiciliary care) - The following are forms, the use of which may be called for in hospitalization for observation and physical examination, in hospital treatment or in domiciliary care:

Form P-10, Application for Hospital Treatment or Domiciliary Care.

Form 1170, Designation of Person to Receive Personal Effects.

Form 404, Statement Regarding Dependents of Persons Receiving Hospital Treatment, Institutional or Domiciliary Care.

Form 505, Request for Data Relative to Domiciliary Care, Hospital or Out-patient Treatment.

Form 653, Notice of Change of Status of Beneficiary Receiving Hospital Treatment or Domiciliary Care.

Form (station), Agreement by Applicants Retired under Public No. 18, 76th Congress, to Pay Per Diem Rate of Hospital Treatment.

Form 2557, Admission Card.

Form 2593, Record of Hospitalization or Domiciliary Care.] (March 6, 1943.)

6088. [FORM P-10, APPLICATION FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.-- See R. & P. 6036 et seq for preparation and filing of this form. When a regional office, including one that is a part of a facility, authorizes admission to an allocated hospital of the Army, Navy or Public Health Service, or to a State, city or private hospital or to the facility of which it is a part, the data, upper half of page 4, under "For Administrative Use Only" will not be filled in, since eligibility for such hospitalization will be determined in the admitting office, and the Form P-10 is to be retained there.] (March 6, 1943.)

6089. [FORM 1170, DESIGNATION OF PERSON TO RECEIVE PERSONAL EFFECTS.-- (A) This form is to be executed by a mentally competent beneficiary, or by the guardian of a mentally incompetent beneficiary admitted for hospital treatment or domiciliary care to a facility under the direct and exclusive jurisdiction of the Veterans Administration. If a mentally incompetent beneficiary has no guardian, the form need not be executed. This form is to be filed with the Form P-10 in the facility correspondence file related to the beneficiary, and is to be transmitted to the receiving facility if and when he is transferred. As indicated by its title, this form guides administrative action to be taken in disposition of such personal effects and funds of a beneficiary as remain in the facility in which he has died or from which he is absent without leave. See R. & P. R-4800-4813.

(B) Form 1170 will not be executed in admission by regional offices (including those a part of a facility) to hospitals other than those under direct and exclusive jurisdiction of the Veterans Administration (that is, to other Federal hospitals which are allocated, State, city or private hospitals). Upon Form 2557, Admission Card, the authorization for these hospital admissions, are to be recorded the same data as to relationships as appear on Form 1170; and consultation of that information on the copy of the Form 2557 that is retained by the admitting office will guide as to disposition of personal effects and funds which remain after the death in or absence without leave from a facility, of a beneficiary.



(C) Question 12, Form P-10, advises the applicant regarding the provisions of Public No. 382, 77th Congress, Act of December 26, 1941 (38 U. S. Code 17-17 j), viz., that, should he die while receiving treatment or care authorized by the Veterans Administration in any institution, and leave no spouse, or next of kin or heir entitled to inherit, all of his personal property, including money or balances in bank, etc., not disposed of by will or otherwise, will become the property of the United States as trustee for the post fund.] (March 6, 1943.)

6090. [FORM 404, STATEMENT REGARDING DEPENDENTS OF PERSONS RECEIVING HOSPITAL TREATMENT, INSTITUTIONAL OR DOMICILIARY CARE.—(A) This adjudication form is to be submitted, within 24 hours after admission of a beneficiary to a facility under direct and exclusive jurisdiction of the Veterans Administration for hospital treatment or domiciliary care, or to another Federal, State, city or private hospital for hospital treatment authorized by the Veterans Administration. It is also used in reporting re-admissions; discharges from hospital treatment or domiciliary care; furloughs for 30 days or more from domiciliation; return from such furloughs; and retention of a beneficiary, for hospital treatment or domiciliary care, upon completion of an episode of hospitalization for observation and physical examination. The beneficiary's answers to the questions on the upper third of the original of the form are to be sworn to; the certification in the lower third as to dates of admission and discharge, etc., is to be made by the manager of a facility under direct and exclusive jurisdiction of the Veterans Administration, the commandant of some other Federal hospital, or the superintendent of a civilian hospital. If the beneficiary be unable, because of his mental or physical condition, to execute the form, it may be completed by the manager, by transposition of data from the beneficiary's Form P-10, or by the commandant or superintendent aforesaid, by inquiry upon the regional office for those data. Further instructions as to submittal of Form 404 appear on its back and in R. & P. 1274-1284. The station copy of this form will be placed in the facility correspondence file related to the beneficiary.

(B) The purpose of Form 404 is to furnish adjudication agencies with information that will effectuate the provisions of Veterans Regulation No. 6 (c), paragraph VI, requiring reduction of monetary awards to beneficiaries, without dependents, who are receiving hospital treatment, institutional or domiciliary care authorized by the Veterans Administration.

(C) Persons Retired from the Armed Forces.—(1) See R. & P. 6046. Retired emergency officers, and officers or enlisted men, who had had war service, retired from the regular establishment (Public No. 198, 76th Congress, and Public No. 365, 77th Congress), when receiving hospital treatment or domiciliary care authorized by the Veterans Administration, are subject to the reduction of retirement or retainer pay they are receiving, and Form 404 is to be executed and submitted as provided in these circumstances.

(2) Such deductions for beneficiaries comprehended by Public No. 198, 76th Congress, will be made by the service from which the beneficiary was retired. Forms 404 for such beneficiaries will be sent (by air mail from facilities west of the Mississippi River) to the following Washington, D. C. addresses, respectively; Bureau of Medicine and Surgery (retired sailors and marines); Finance Officer, United States Army, retired pay branch; Commandant, United States Coast Guard.

(3) The amount of the reduction (that is whether to \$15 or \$6 monthly) during hospital treatment or domiciliary care of such retired beneficiaries is de-



pendent, not upon whether the disease or injury for which hospitalization or domiciliation was provided is or is not service connected, but upon whether the disability for which the beneficiary was retired is or is not service connected.

(4) Since personnel, not Regular Establishment, retired from the Army under Public No. 18, 76th Congress, and Public No. 262, 77th Congress, (see R. & P. 6046(C)) are required to pay a per diem (subsistence) rate while receiving hospital treatment in a facility under direct and exclusive jurisdiction of the Veterans Administration, and, for that reason, are regarded as not being furnished hospital treatment, etc., by the United States, no Form 404 need be prepared and submitted in such admissions.

(D) The execution of Form 404 is required when an ex-member of the armed forces, in receipt of a monetary award from the Veterans Administration is, as a beneficiary of another Federal agency, furnished hospital treatment by the Veterans Administration.

(E) When a beneficiary, residing in the vicinity of a facility, is admitted thereto for construction of artificial dentures and, in accordance with prescribed procedure, is, following that admission, given a leave of absence until those dentures are finished and ready for fitting, a Form 404 need not be prepared and submitted. However, when a beneficiary is admitted for dental treatment and actual maintenance is involved, as contemplated by Veterans Regulation No. 6 (c), a Form 404 is required, as in any other admission for hospital treatment.

(F) Penalty envelopes may be supplied officers in charge of State soldiers' homes, State penitentiaries, county jails, etc., for inclosure of Forms 404 that are being submitted to the Veterans Administration. See also R. & P. 1062. (March 6, 1943.)

6091. FORM 505, REQUEST FOR DATA RELATIVE TO DOMICILIARY CARE, HOSPITAL OR OUT-PATIENT TREATMENT - This adjudication form is used by a facility manager or chief medical officer, or by the chief, out-patient service, in securing information to be used in determinations of eligibility for hospital treatment (or out-patient treatment) or domiciliary care. The data called for by the questions on this form are self-explanatory, and correspond closely to those on page 4, Form P-10, which are to be filled in by a regional office in forwarding a Form P-10 to a facility. This form is to be prepared and forwarded in duplicate. The addressee (adjudication officer, director of veterans claims service) will complete both forms, will return the original to the inquiring station, and will place the duplicate in the case file of the applicant. The original, after it has been returned to the manager or chief medical officer who requested the data, will, after being used for the determinations, be filed in the beneficiary's correspondence file (or, if eligibility to out-patient treatment is concerned, in his medical file). The data supplied on this form are not to be copied on the related Form P-10, but filed with the latter. (March 6, 1943.)

6092. FORM 653, NOTICE OF CHANGE OF STATUS OF BENEFICIARY RECEIVING HOSPITAL TREATMENT OR DOMICILIARY CARE.--(A) This form is to be executed and forwarded, by an adjudication officer in a station having possession of the case file concerned, to the facility in which the beneficiary is hospitalized or domiciled [     ]. The adjudication officer will complete this form in duplicate, will file the copy in the case file, and transmit the original. When the original has reached the facility it will be at once routed to the eligibility clerk who, after it has served his purpose, will forward it for incorporation in the beneficiary's correspondence folder.



(B) [A Form 653 will be executed and forwarded in all initial adjudications and when, upon subsequent adjudication, there is a change made in the status as to service connection of any of the diseases or injuries of the beneficiary. The form will bear a concise statement of the circumstances that obtain.] (May 15, 1944.)

6093. AGREEMENT, BY APPLICANTS RETIRED UNDER PUBLIC NO. 18, 76TH CONGRESS, TO PAY THE PRESCRIBED HOSPITAL PER DIEM CHARGE. - See R. & P. 6046 (C). This executed agreement will be filed in the beneficiary's correspondence folder at the facility. (March 6, 1943.)

6094. FORM 2557, ADMISSION CARD. - (A) This form is used to authorize:

1. Hospital observation and physical examination of claimants and beneficiaries of the Veterans Administration, for the purposes of monetary awards (pension, disability compensation, insurance, etc.), in facilities or diagnostic centers.

2. Hospital observation and physical examination, when requested, of claimants or beneficiaries of other Federal agencies (United States Civil Service Commission, Employees Compensation Commission, Railroad Retirement Board, etc.), and Canadian or British pensioners.

3. Hospital treatment of ex-members of the armed forces in facilities other than those under direct and exclusive jurisdiction of the Veterans Administration (that is, in other Federal hospitals allocated to the regional territory, State, city or private hospitals).

4. Hospital treatment of beneficiaries of other Federal agencies (e.g., Employees Compensation Commission; personnel of the Army, Navy or Marine Corps in active service; patients of the Public Health Service) and pensioners of Canada or Great Britain.

5. Hospital treatment of persons retired under Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress, (see R. & P. 6046 (C)).

6. Inter-facility transfers for treatment; or references of patients from facilities to diagnostic centers for advisory opinion.

7. Temporary hospitalization to complete an examination begun in outpatient service.

8. Hospital admission, ordered by managers, to determine fitness of an employee of the station to carry on his duties (see R. & P. 9670-9671, 9718).

(B) Form 2557 is to be executed in duplicate. The original is to be sent to the receiving hospital, as authorization for the admission. The copy is to be retained at the authorizing station. After completion of the entries on the back of the form, the original is to be separated into halves along the midline perforation.



The top half is given to the applicant or his attendant if there be one; the lower half is mailed or otherwise delivered to the receiving hospital where, upon receipt of both halves, they are to be assembled.

(C) Admission for hospital observation and examination and for hospital treatment will not be simultaneously authorized; one or the other, as indicated, will be specified and the inapplicable phrase typed out. A facility under direct and exclusive jurisdiction of the Veterans Administration may, with consent of the beneficiary, retain him for hospital treatment after termination (and report) of a period of hospital observation which had been authorized; and the station which had authorized admission for hospital observation will be informed of this change of status to hospital treatment by a copy of a supplementary Form 2593, which must be so supplied when the facility has continued hospitalization for treatment purposes.

(D) When a claimant or beneficiary is being admitted to a facility from its out-patient unit, the Form 2557 will be addressed to the facility itself.

(E) It is especially important that the data on Form 2557 be accurate when admission to a Federal facility other than one under direct and exclusive jurisdiction of the Veterans Administration is being authorized, because such data are to be transferred to Form 2593 submitted by such hospitals.

(F) The original Form 2557 received at the facility of admission will be incorporated in the beneficiary's correspondence file, if there be one.

(G) The copy of Form 2557 which is retained at the station which authorized the admission, will be put in the medical file (for out-patient service) of the beneficiary, if there be such file. If not, that copy will be placed in such alphabetically-arranged miscellaneous file as is maintained at the station. This latter procedure will be followed in all cases when the person authorized admission was other than a claimant or beneficiary of the Veterans Administration. All copies of Form 2557 which are incorporated in such miscellaneous files will, after expiration of one year, be recommended for disposition as inactive records; provided that if any such copy be related to a claimant or beneficiary of the Veterans Administration, and a medical file has in the meantime been created for him at the station, such copy will be made a part of the contents of such medical file.

(H) In interfacility transfer, that copy of Form 2557 which is retained at the facility making the transfer will be filed with the inactive correspondence file of the beneficiary.] (March 6, 1943.)

6095. [FORM 2593, RECORD OF HOSPITALIZATION OR DOMICILIARY CARE.--(A) This form is of especial administrative importance. Its accurate execution is essential for statistical purposes and for medical reasons. It is the basis for statistical data in the annual report of the Veterans Administration; it guides administrative policies and action; it reflects, in its medical data, the type of care provided beneficiaries and the results secured in their care and treatment, as compared with other Government, State, municipal and private hospitals. It is obvious, therefore, that constant supervision must be exercised by administrative officials over the clerical personnel handling these cards. This supervision is expected of chief medical officers or clinical directors or their designates (who must be carefully selected, if assigned at all to this supervision). Such supervision will be insisted upon, and the employees named will be held responsible for the prompt and satisfactory preparation and distribution of these forms.



(B) Form 2593 is printed on white, green and red paper. It is to be executed in triplicate (a white original, green and red copies) for ex-members of the armed forces of the United States, admitted for hospital treatment or domiciliary care under R. & P. R-6047. For all other classes of admissions for hospital treatment (e.g., beneficiaries of the Employees Compensation Commission, Civil Service Commission, Canadian or British pensioners, etc.), the red copy will not be required, and only the original and green copy will be prepared.

(C) The white card is to be forwarded to the budget officer and chief of statistics, central office. The green card is to be retained at the station of issuance. If the location of the beneficiary's case file is known when the form is prepared, the red card will be sent to the station in possession of that case file, for incorporation therein. If the location of the case file be unknown, the red card will be forwarded to the chief clerk, central office. No case file red card is required for any hospitalized persons other than claimants or beneficiaries of the Veterans Administration; that case file copy is for consultation in authorizing readmission of such applicants to facilities, to ascertain if any period of exclusion which had been imposed because of an irregular discharge from hospitalization or domiciliation, remains unexpired.

(D) Care must be taken to avoid waste in requisitioning and in supplying stocks of Form 2593, to preserve proportionate relations of the differently colored cards in respect to their prescribed distribution.

(E) Managers of regional offices and of facilities with regional office activities, through chief medical officers and their designates, will be responsible for preparation and distribution of Forms 2593 related to beneficiaries of the Veterans Administration who were authorized hospitalization in State, city or private hospitals. Federal hospitals will prepare and directly submit Forms 2593, related to patients authorized treatment therein by the Veterans Administration, in the manner provided in (B) hereof, and subject to instructions and supervision of chief medical officers and their designates.

(F) The typing of Forms 2593 will be done with care. The white card will be the ribbon copy. Good carbon paper will be used, and the original and the copy (green) or copies (green and red) as required will be arranged so that entries will be aligned above or opposite the printed items.

(G) To prevent delays in submittal of these forms, ward physicians will be instructed promptly to supply the clinical clerk with information regarding initial and changed diagnoses, either during hospitalization or at its close. Care is essential in the listing of diseases in their proper order on these forms. (March 6, 1943.)

6096. [NOTATIONS ON FORM 2593.--The notations to be entered on Form 2593 are largely suggested by the captions. The following will guide to uniform execution of these notations:

(A) CLASS OF BENEFICIARY--The identity of the class of admission will be symbolized thus:

1. Observation and examination of an employee of the Veterans Administration to determine fitness to perform his official duties - VA Emp.

2. Observation and examination of an annuitant or applicant for annuity, Civil Service Retirement - CS Ret.



3. Observation and examination of applicant for annuity, Railroad Retirement Board - RR Ret.
4. Observation and examination of claimant of Employees Compensation Commission - ECC.
5. Observation and examination of pensioner of Canada or Great Britain - Can. or Brit.
6. Observation and examination of claimant or beneficiary of the Veterans Administration - VA.
7. Examination of registrant, requested by Selective Service System or Army Induction Stations - Regist.
8. Treatment of sailor or marine, active service - Navy.
9. Treatment of soldier, active service - Army.
10. Treatment of beneficiary of Employees Compensation Commission - ECC.
11. Treatment of Canadian or British pensioner - Can. Pen. or Brit. Pen.
12. Treatment of employee - Emg. Emp.
13. Treatment of member of employee's family - Emg. Emp. Fam.
14. Treatment of injured civilian - Emg. Civ.
15. [Treatment or domiciliary care of ex-member of the armed forces - a triple symbol will be entered, that is SC, NSC, ILOD or NILOD, dependent upon whether the disease or injury for which the beneficiary was admitted is or is not service connected or was that disease or injury which led to his discharge for disability; Hosp. or Dom., dependent upon whether the beneficiary was admitted for hospital treatment or domiciliary care; and R-6047, followed by (A) to (E) inclusive, indicating the subparagraph under which eligibility was determined. Thus, a beneficiary who served in a war, and who was admitted for hospital treatment of a service-connected disease or injury, would be designated SC; Hosp; R-6047 (A). A beneficiary with peacetime service only, admitted for domiciliary care for a condition not service connected would be symbolized NSC; Dom.; R-6047 (D). A beneficiary who had served in a war and was admitted for hospital treatment of a condition not connected with service would be designated NSC; Hosp; R-6047 (C) or (E). A beneficiary who had been discharged from active military or naval service for disability held as incurred or aggravated in line of duty and was admitted for hospital treatment of that disability would be designated ILOD; Hosp; R-6047 (A) or (B), dependent upon whether he served during a period of war or peacetime. A beneficiary who had been discharged for disability not incurred in line of duty and admitted for hospital treatment of that disability or a beneficiary who had been discharged for disability held as incurred or aggravated in line of duty but admitted for hospital treatment of a different disability would be symbolized NILOD; Hosp; R-6047 (C), (D) or (E) dependent upon his period of active service.

The symbols ILOD and NILOD will be used only when the evidence available indicates that the beneficiary has not filed a claim for disability compensation or pension or his claim although filed has not been adjudicated. Upon receipt of Form 653, Notice of Change of Beneficiary Receiving Hospitalization or Domiciliary Care, or other evidence, the data received will be checked against the symbols ILOD or NILOD on Form 2593 and a supplemental Form 2593, if indicated, reflecting the change of status will be submitted as provided in R. & P. 6097 (B) (1). A supplemental card will not be submitted if a beneficiary (Paragraph 6096 cont'd.)



symbolized ILOD is granted service connection for that disability on account of which he was discharged from military or naval service and admitted for hospital treatment nor will a supplemental card be submitted for a beneficiary symbolized NILOD if service connection is denied.

Persons separated from active military or naval service on and after December 7, 1941, will be reported for statistical purposes, as "World War II", over the item "War".] (August 31, 1944.)

16. Retired Beneficiaries--The admission, for hospital treatment or domiciliary care, of an applicant retired from the regular establishment under Public No. 198, 76th Congress, and Public No. 365, 77th Congress, will be symbolized SC or NSC, dependent upon whether his disability is or is not service connected; Hosp. or Dom., dependent upon whether hospital treatment or domiciliary care was provided; and R-6047 (A), (C) or (E), because such applicants must have had war service. A further identifying symbol, P.198, will be added, signifying Public No. 198, 76th Congress.

A beneficiary hospitalized for treatment under Public No. 18, 76th Congress, and Public No. 262, 77th Congress, will be symbolized SC or NSC, dependent upon whether he is admitted for treatment of the disease or injury for which he was retired from the Army, or for some other condition not related to his military service. That symbol will be followed by the further identification, P.18, signifying Public No. 18, 76th Congress. No domiciliary care is authorized for these applicants and they are not admitted for hospitalization under the eligibility provisions of R-6047, hence the abbreviated symbols identifying them for classification purposes.

Admission for hospital treatment or domiciliary care of a retired emergency officer, World War, will be symbolized, as provided in 15 hereof with addition of the symbol "EOR", signifying emergency officers retirement.

17. A civilian employee of the War Department or Navy Department, referred by an Army or Navy official, for injury in performance of duty, under the Federal Compensation Act, would be reported Army (or Navy) CIV:ECC. If the claim of such injured employee be approved by that Commission, the supplemental card would show status changed to ECC.

(B) C-Number and Register Number--The C-number is that of the case file of the beneficiary. If such number had not been assigned, enter "Not assigned". The register number is the latest facility register number given upon the admission.

(C) Race - W, white; N, negro; Ind., Indian.

(D) Marital Status - M, married; S, single; D, divorced; W, widower or widow.

(E) Birthplace - Enter State, if native-born; country, if foreign-born.

(F) Date of Most Recent Military Service - Enter date of most recent induction into Federal service, as well as date of discharge from such service.

(G) Admitted By - Enter designation (that is, facility, regional office) and location of the station which authorized the admission. In admissions for treatment or domiciliary care this will be the same facility; and that may also be the case when the admission is authorized, for observation and physical examination, upon request of the adjudication officer of a facility with regional office activities. In interfacility transfers, the facility that transferred the beneficiary will be recorded. When temporary hospitalization is effected to complete an examination begun in the out-patient unit of the same facility, no Form 2593 is required to re-



cord such admission, but a complete Form 2593 will be prepared and submitted upon termination of such hospital episode. If the request for admission came from central office, that office will be named.

(H) Diagnosis - Using the nomenclature approved by the Veterans Administration (see Manual for Medical Examiners for the American Psychiatric Association Classification of Psychoses and Psychoneuroses, and the modified American Heart Association's Classification of Diseases of the Heart and Blood Vessels; and the Nomenclature of Diseases and Conditions, for general medical and surgical disorders), there will be recorded the diseases and conditions composing the complete diagnoses, in the order of their severity and importance. The major condition for which the beneficiary is admitted will be first entered on line 1, followed by the associated diseases or injuries, in the sequence of their relative gravity. The major disease must agree with the general classification of patients which is reported on Form 2601, the Monthly Report of Hospitalization and Domiciliary Care; and, to insure such correspondence, there will be entered, before the word "Diagnosis", the general classification (Paragraph 6096 cont'd.)







cation under which the case was reported on the said Form 2601. Accordingly, on all Forms 2593 (the incomplete admission card, supplemental and completed cards) will be so entered the symbols TB (for tuberculosis), PSY (for psychosis), ONP (other neuropsychiatric disorders) or GMS (for general medical and surgical conditions).

The diagnosis number will be entered to correspond with the nomenclature code-number.

Under service origin, indicate by X, opposite each listed disease or injury under diagnosis, whether it is or is not service connected. Information to guide in this may be obtained from the case file of the beneficiary, if it be in possession of the facility; or from the admission card, Form 2557; or from the data which will have been entered on the upper half of page 4 of a Form P-10 that had been forwarded by a regional office.

Loss of vision of 5/200 in both eyes will be recorded as total bilateral blindness.

Under treated, indicate by X such diseases or injuries as had received treatment.

(I) Result of Treatment - Enter cured, improved, unimproved for each disease or injury that was treated. For such conditions as were not treated, record condition at discharge. Thus, in pulmonary tuberculosis, the entries would be apparently cured, apparently arrested, quiescent, improved, unimproved, or died, in conformity with the classification of the National Tuberculosis Association, adopted by the Veterans Administration.

(J) Complications, Sequelae, etc.--Record the important complications, sequelae or intercurrent conditions which arose during the hospitalization.

(K) Operations - Using the official nomenclature for names and numbers, fill in the spaces and columns for operations performed during the hospitalization just ended, recording condition or disease for which each was performed, the date of the operation, the anesthetic used (G for general, L for local) and the result, that is, successful, unsuccessful, died. Dental operations, such as insertions of fillings, removal of salivary deposits, prophylaxis treatment, etc., will not be recorded; but extraction of teeth, construction of artificial dentures, removal of tumors and cysts, reduction of fractures and oral surgical operations will require entries.

(L) Disposition (1) record discharge, death, transfer to another facility, and transfer from hospital to barracks at the same facility. In reporting transfer to domiciliary care from hospital, same facility, there will be shown, after reason for disposition, the disease or injury for which domiciliary care was authorized.

(2) Regular discharge of a patient contemplates that he shall have been continued under treatment to its completion, that is, until maximum benefit has been achieved, or cure or improvement has been effected. An act of the patient may interrupt treatment before such completion, and call for an irregular discharge (as against medical advice, absence without leave, disorderly conduct). Except that an irregular discharge cannot be charged against a mentally incompetent patient, the general principles as to discharges of the tuberculous patients or those with medical and surgical disorders apply equally to neuropsychiatric patients; their formal discharge is given with propriety when they have so improved that a satisfactory extramural adjustment is thought probable. Such improved patient may be discharged from the facility, or he may be discharged at his home, upon expiration of a trial visit which had been granted. Because the elopement of a mentally incompetent patient means interruption of hospital treatment before it is completed, the recordation of (Paragraph 6096 cont'd.)



"Discharge" for such patients, when they have not been located, is inconsistent with the principles aforesaid. Moreover, such disposition by "Discharge" following elopement invites difficulties with State statutes which require recommitment when a discharge has been made. For these reasons, the elopement of a mentally incompetent patient will be entered, opposite disposition, Form 2593, as "Elopement;" and that status will continue until such patient is apprehended and rehospitalized, or until there has expired that period (90 days or up to a year) which is authorized under the statutes of the State in which the facility concerned is located as to maximum period of a trial visit before recommitment is required. If such eloped patient is apprehended and rehospitalized, the action as to submittal of Form 2593 will be in accordance with R. & P. 6067 (B)(4). If it is ascertained that the eloped patient has returned to his home; his guardian or nearest relative accepts responsibility for him; and, in the opinion of the manager of the Veterans Administration facility concerned, rehospitalization is not necessary, discharge may be recorded upon a complete Form 2593, then to be submitted. The same action will be taken when, an eloped patient not having been apprehended, the maximum period that is allowed under the State law concerned for a trial visit, without recommitment, has expired, so that the status of elopement has to be closed out and final disposition made.

(M) (1) Reason for Disposition - Record this in accordance with the circumstances; thus, for discharges: treatment completed, terminal condition, maximum benefit, no hospital treatment needed; found ineligible (give brief explanation under remarks); treatment obstructed; observation completed, observation obstructed; after elopement; expiration of trial visit; against medical advice, absence without official leave, disorderly conduct; statutory, under Public No. 141, 73d Congress, or under R. & P. R-6065 (C) (related to tuberculous patients). For interfacility transfers, give reason, thus: To facility adopted for treatment; for domiciliary care; for advisory opinion (as when a facility is requesting advice of a diagnostic center). In all discharges carrying penalty of exclusion from readmission for either hospital treatment or domiciliary care for a prescribed period, the legend "disciplinary" will be stamped after reason for disposition. In discharges against medical advice, the patient will be asked to sign the certificate on the back of Form 2593, green copy. If he refuses, it will be so stated in the same space.

(2) When an elopement status is being closed out, for any reason defined in (L)(2) hereof, the notation will accord with the presented circumstances. If the eloped patient is brought back to the facility from which he escaped, a supplemental Form 2593 would be submitted with the notation: "Eloped (date); rehospitalized this facility (date)". No new Form P-10, application for hospital treatment, nor any formal authorization for readmission (Form 2357) need be executed to cover such rehospitalization of an apprehended eloped patient in the same facility; nor will a new register number be assigned. If (see R. & P. 6067 (B)(4)) the eloped patient, upon apprehension at a distant point, is readmitted to another facility at that point, the facility from which he had escaped, upon being informed, will prepare and submit a complete Form 2593, showing disposition by discharge; with the notation opposite reason for disposition: "Eloped (date); readmitted to facility at (location (date)); dropped from register of this facility". If the eloped patient is reported to have returned to his home, his guardian or family wish to keep him there, and it is the opinion at the facility of elopement that his rehospitalization is not necessary, he may be placed in trial visit status. A supplemental Form 2593 will in



that case be submitted, with the explanatory notation: "Eloped (date); returned home; trial visit authorized (date) for (period assigned)". If the eloped patient is not apprehended before termination of that period allowed by the laws of the State as a maximum period for trial visit, a complete Form 2593 will be submitted, showing disposition by discharge, with the explanatory notation: "Eloped (date); not apprehended; clearance of status required by State law; dropped from register this facility (date)".

(3) When it is necessary to transfer a psychotic patient from one facility to another to obtain special treatment not available at the facility of reference, care will be taken to identify the action, not as a discharge but as an "interfacility transfer for special treatment; return to this station proposed". This is especially important when the referring facility is operating under State licensure (as in Massachusetts, New York and Pennsylvania) which requires commitment of all patients, and when the interfacility transfer would entail removal of the psychotic patient outside the jurisdiction of the State.

(4) During the period an escaped psychotic patient is carried in "Eloped," his hospital bed will not be reserved, but will be cleared for use by other applicants. Corresponding entry will be made under item 3, Table No. 1, Form 2601, Monthly Report of Veterans Administration Facilities.

(N) Cause of Death - The entries will correspond to those in the death certificate. Both direct and indirect (contributory) causes will be recorded.

(O) Actual Number of Days in Hospital - Record the total, exclusive of days of leave of absence or trial visit. The day of admission and day of discharge will be computed as one day. When beneficiaries who, admitted for construction and fitting of artificial dentures, are promptly thereafter given leave of absence to return home until recalled, the cypher 0 will be entered.

(P) Remarks - Opposite Remarks, back of Form 2593, will be recorded the type of any prosthetic appliance of a permanent type (e.g., artificial limb, eye, hearing device, brace, etc.) supplied the beneficiary during hospital treatment or domiciliary care. This space may also be used for explanation of any unusual circumstance related to a patient's condition or his admission, transfer, discharge, etc., thought necessary.

(Q) Leaves of Absence and Trial Visits - Entries under these captions, back of Form 2593, will be guided by instructions in R. & P. 6097.

(R) No notations other than as provided will be made on the reverse of Form 2593. (March 6, 1943.)

6097. SUBMITTAL OF FORM 2593.--(A) As soon as possible, and not later than forty-eight hours after admission of every claimant or beneficiary, for hospitalization or domiciliary care (except in temporary hospitalization to complete an outpatient examination), the first Form 2593 will be executed and distributed as provided in R. & P. 6095 and 6096. [The upper third of the form will be completely executed and, if the diagnosis or diagnoses have been determined, appropriate entries will be made under "diagnosis," with the diseases or injuries listed in the order of their severity and importance. If the diagnosis is not determined when this first Form 2593 is prepared, a supplemental form will be submitted as soon as it is established. It is essential that the most important disease or injury for which the patient has been hospitalized be listed on the first line.]



(B) During Hospitalization or Domiciliation - Any change in his status which occurs while a beneficiary is receiving hospital observation, hospital treatment or domiciliary care, will be reflected in [a supplemental report. The indications for preparation and submittal of a supplemental Form 2593 are:

1. When there is change in class of beneficiary, as from service-connected (SC) to nonservice-connected (NSC) or vice versa.

2. When the diagnosis is undetermined at the time that the first Form 2593 is submitted, so that the diseases or injuries cannot be entered, under "Diagnosis," in their order of severity and importance, a supplemental Form 2593 will be submitted as soon thereafter as the diagnosis has been established.]

[3.] When hospital treatment is changed to domiciliary care and vice versa.

[4.] When hospital observation and examination is changed to hospital treatment or domiciliary care.

[5.] When an employee of the Veterans Administration, hospitalized following filing of a claim with the Employees Compensation Commission, has that claim denied but, being found eligible for continuance of hospital treatment as an ex-member of the armed forces, is changed to the status of a Veterans Administration beneficiary.

[6.] When a civilian employee of the Army or Navy, hospitalized as a potential beneficiary of the Employees Compensation Commission [and first reported as (Army) (Navy) (Civ.: ECC), has his claim accepted] and is authorized continuance of treatment by the Commission, so that the changed symbol will be ECC.

[7.] When there is change of diagnosis of the main [disease or injury, or additional diagnoses are made.]

[8.] When a beneficiary goes on permitted leave for a period of thirty days, and when he returns therefrom. The supplemental [Form 2593] reporting the beginning of such leave will show, opposite "Disposition," the notation "On leave" and, opposite date of disposition, the date he left. The card reporting his return will show, opposite "Disposition," the notation "Returned from leave" and, on the back, [ ] the dates of departure and return. When the leave of absence is for less than thirty days, the preparation and submittal of the supplemental card will be withheld until a complete Form 2593 is to be executed to report discharge, transfer or death [ ] at which time all leave granted during his treatment or care will then be recorded on the back of the complete Form 2593.

[9.] When a psychotic patient is given a trial visit, a supplemental Form 2593 will be submitted, showing grant of the trial visit and its assigned duration. Upon return of the patient, a supplemental card will be [submitted to show the return]. Should such beneficiary be discharged from trial visit, that action will be reflected in a complete Form 2593, showing disposition, with notations under trial visit on the back of the card.

[10.] The effective date of any change of status provided in 1 to [9] will always be clearly entered.

[11.] A supplemental Form 2593, like the first or admission card, does not require that fulness of data [that is] necessary for the complete or final Form 2593. All the data necessary for it are those above the first double line on face, [the diagnoses in order of severity and importance, and] the notation of change of status.



(C) Upon Disposition by Discharge, Death or Transfer - When a hospitalized or domiciled beneficiary is discharged, transferred to another facility or dies, what is called the "Complete" Form 2593 is to be prepared and submitted. This will show fully and clearly all necessary entries described under R. & P. 6096. These complete cards will be submitted as promptly as possible after disposition of the beneficiary, and not later than three days after. When information additional to what was given on a complete Form 2593 which had been submitted has been developed by autopsy or other circumstances, a corrected Form 2593, incorporating the later information, and identified as "Additional complete card" will be executed and submitted. When a patient transferred from one facility to another for some special service (as in transfer to a tumor clinic or to a diagnostic center for opinion as to identity of the disease and its indicated therapy) dies in the facility to which he was transferred, the complete Form 2593 will bear an entry under remarks, "Transferred (date) from (location or facility);" and a copy of that form will be sent to the manager of the facility from which the patient had been transferred. Upon its receipt, it will be affixed to the green, complete Form 2593 which had been prepared and placed in the inactive section of the clinical records file, when the patient had been transferred. The two cards will become part of the inactive clinical records file.

(D) At the bottom, right hand side of each Form 2593, opposite the title of the form, will be typed, preferably with red ribbon, the words, "Admission," "Supplemental" or "Complete," respectively, to identify the card that is submitted. (December 20, 1943.)

(E) The station (green) copies of Form 2593, including the admission, supplemental and complete cards, become components of the clinical records file. The active part of that file, related to beneficiaries who are receiving hospital treatment, consists of the admission and supplemental Forms 2593. The inactive part consists solely of copies of complete cards, prepared when disposition of patients is made by discharge, transfer to another facility, transfer from hospital to barracks at the same facility, or death. When a complete Form 2593 is placed in the inactive part of the clinical records file, the previous cards - admission and supplementary - related to the beneficiary will be taken from the active part of the clinical records file, stored, held for six months, and then destroyed. To any complete Form 2593 placed in the inactive part of the clinical records file will be added the complete card that is executed upon any subsequent episode or episodes of hospital treatment of the beneficiary, and the combined filing will be under the register number most recently assigned. [ ] (March 27, 1944.)

(F) For preparation and submittal of Form 2593 by State Soldiers' Homes, and disposition of such forms by regional offices and facilities with regional offices having jurisdiction, see R. & P. 7883 (K), (L) and (M). (December 20, 1943.)



## CLINICAL RECORDS

6100. PURPOSE OF CLINICAL RECORDS - Clinical Records, Form 2614 series, incorporating details of physical and laboratory examinations which are made, and all types of therapy which are administered, will be prepared for each patient who receives hospital treatment in facilities under direct and exclusive jurisdiction of the Veterans Administration. Accuracy, neatness, clarity and sufficient fulness are essentials in the preparation of clinical records, not only to conform to professional standards, but also because such records may be required in the adjudication of claims for monetary benefits, especially for death compensation, or may have to be produced in court suits for Government insurance. (March 22, 1943.)

6101. COMPONENTS OF CLINICAL RECORDS.--The forms which compose a complete clinical record are:

- (A) 1 - Form 2614a - Brief  
2 - " 2614b - Family and Personal History  
3 - " 2614b-1 - Social Data  
4 - " 2614c - History of Present Disease  
5 - " 2614d - Objective Symptoms (Physical Examination)  
6 - " 2614d-1 - Initial Examination of Chest (and Periodic Re-examinations)  
7 - " 2614d-2 - Neuropsychiatric Examination  
8 - " 2614d-3 - Skin Sensitization Tests  
9 - " 2614d-4 - Exercise Record  
10 - " 2614d-5 - Pneumothorax Therapy Chart  
11 - " 2614e - Graphic Chart  
12 - " 2614f - Weight Chart  
13 - " 2614g - Operation Record  
14 - " 2614h - Roentgen examination  
15 - " 2614h-1 - Roentgen Therapy  
16 - " 2614i - Laboratory Examinations  
17 - " 2614i-1 - " "  
18 - " 2614j - Ward Physician's Progress and Treatment Record  
19 - " 2614k - Nurse's Progress and Treatment Record  
20 - " 2614-l - Occupational Therapy  
21 - " 2614m - Physical Therapy  
22 - " 2614n - Post-Mortem Record  
23 - " 2614n-1 - " " "  
24 - " 2614n-2 - " " "  
25 - " 2614p - Dental Record  
26 - " 2614q - Report of Electrocardiogram  
27 - " 2614r - Anti-Syphilitic Treatment  
28 - " 2614s - Electroencephalography  
29 - " 2614t - Electric Shock Treatment (December 20, 1943.)

(B) The folder to contain such of these component forms as have been executed in the individual case, will be of plain manila, with the legend "Clinical Records" stamped, typed or written in ink on its front; and with the name, C-number and facility register number of the patient on the tab. A Marvel or other perforator, and the Acco or similar fastener will be used for perforating and fastening the sheets in the folder, at the top margin.

(C) When there are several reports on the same subject (e.g., sputum examinations, temperature charts, special treatment reports, etc.), these will be arranged in chronological order, with the most recent nearest the front of the file.



(D) Only when specifically authorized by central office will a carbon copy be made of any material composing the clinical record. (March 22, 1943.)

6102. NOTATIONS IN CLINICAL RECORDS.--(A) As hereinafter provided in duties of the clinical clerk, stenographers, typists or clerks may be assigned under prescribed conditions for detached work in wards, clinics or laboratories, to assist in preparing clinical records. Reports of physical or laboratory examinations may be written in longhand for copying by typists, or may be dictated to stenographers, or into dictaphones for transcription. Notations on Form 2614j by ward physicians and on Form 2614k by nurses will be penned, unless the manager of the facility concerned authorizes the typing of such notations. Duplicate copies of laboratory reports on the applicable forms of the 2614 series will not be maintained in laboratories, except that a copy of the interpretation of a radiogram may be slipped into the jacket holding the film. Laboratory employees will retain their work sheets or penciled data for one month after they have submitted reports on the prescribed Form 2614 series and, at the end of that period, those work sheets will be [destroyed]. Managers, in a station order, will caution messengers, attendants and other employees to exercise constant care against loss of completed clinical records sheets which are being sent from laboratories to wards or clinics, and from those points to the clinical clerk's office. (December 20, 1943.)

(B) The first form in the clinical records series, Form 2614a, the Brief, will be completed in its upper third (above diagnosis, etc.) by the clinical clerk in admissions during regular hours, or by the officer of the day in admissions at other than regular hours, from information elicited from the patient or his attendant, and from any exhibits (Notice to Report, Form P-10 or Form 2557, etc.). The patient's surname, first and middle names must be accurately, fully and legibly recorded; and equal care must be taken to note his permanent address (State, city, street and number), the person to be notified in emergency, relationship if any of such person to the patient, etc. Upon conclusion of the hospital treatment, the data on the lower two-thirds of the front and on the reverse of Form 2614a will be completed by the ward physician (by longhand transcription from other hospital records), so that this form and other forms to be completed by the ward physician will be in possession of the chief medical officer or clinical director not later than 10 a. m. the day of proposed discharge, for presentation at the discharge conference.

(C) Form 2614b, the Family and Personal History, will contain compact but explicit entries. The name of the patient's father, maiden name of his mother, and dates and places of their births will be recorded; and, if either or both are dead, the age at death and cause of death will be stated, if elicited. If either or both parents are living, give their age, occupation and present state of health. In admissions at other than regular hours, when the patient is unconscious or mentally incompetent, and is accompanied by an attendant who is departing after delivery of such patient, this form as well as Form 2614c, History of Present Disease, will be executed by the officer of the day. In admissions during regular hours, Forms 2614b and 2614c will be completed in the reception wards.

(D) Form 2614b-1, Social Data, should carry sufficient data as to the medical and industrial history, previous medical treatment received from other sources, with dates and names of physicians and hospitals, school history, etc.

(E) Form 2614c, History of Present Disease - The captions are self explanatory: entries should be sufficiently clear and full.



(F) Form 2614d, Objective Symptoms (Physical Examination) - The instructions at top of this form will guide. The examiner will begin his answers with the first consideration, "General Appearance," and proceed in sequence. The heading will be recorded first, followed by a brief but explicit answer. Both normal and abnormal findings are to be reported. The diagrams on the back may be used to indicate the location of a lesion, with use of red ink preferably. Extra plain white sheets can be used for extension of data that cannot be contained on the face of Form 2614d. Such sheet or sheets will be numbered, identified at the top by the name, C-number and register number of the patient and date of his admission, and fastened to the back of the form. The "Brief Summary of Findings Leading to Diagnosis," called for, will relate to the major condition, and will consist of a brief specialistic history, and brief statement of the physical findings and the laboratory examinations, followed by a correlation of all the evidence upon which the diagnosis rests. A resume of the treatment should be added. If the patient is referred for examination by a specialist of the staff, his report may serve. This summary should be prepared as soon as special X-ray or other laboratory examinations are available.

(G) Form 2614d-1, Initial Examination of Chest - This form is not for use in lieu of Form 2614d, but to supplement it. Upon the reverse of Form 2614d-1 are to be recorded the findings at the periodic reexaminations of the chest of tuberculous patients which are made to ascertain the progress of the lesions. The intervals between these re-examinations will be determined by the chief medical officer, clinical director, or chief of tuberculosis service, dependent upon the relative acuteness of the process in the individual cases. However, all tuberculous patients will have follow-up physical examinations at least every two months. The notations as to graduated exercise and occupational therapy must be made; they may be produced as evidence in court suits for Government insurance. See Form 2614d-4, Exercise Record, for detailed record of graduated exercises.

(H) Form 2614d-2, Neuropsychiatric Examination - In facilities primarily for neuropsychiatric patients or those with a separate unit for them, the findings in the physical examination and chest examination of such patients will be entered on this form (instead of Forms 2614d and d-1), together with the report of the neuropsychiatric examination, so as to assemble the full physical and mental findings. The captions on Forms 2614d and d-1 will be set down on Form 2614d-2 and followed through. Additional plain white sheets will be used for extension of the examination report. Each such extra sheet will be numbered, identified by the name, C-number, register number and date of admission of the patient, and fastened to Form 2614d-2.

(I) Form 2614d-3, Skin Sensitization Tests - The list of allergens on this form, to be used for skin-testing of allergic patients, may be supplemented by listing on separate plain white sheets, to be fastened to Form 2614d-3, and to bear the name, C-number, register number and date of admission of the patient. Consult Clinical Bulletin No. 29; Allergy.

(J) Form 2614d-4, Exercise Record - This form, replacing mimeographed station forms, will be used to record temperature and pulse findings before and after graduated exercise of tuberculous patients.

(K) Form 2614d-5 Pneumothorax Therapy - the captions of this form are self-explanatory.

(L) Forms 2614e, Graphic Chart; f, Weight Chart; g, Operation Record; h, Roentgenological Report; i and i-1, Laboratory Examinations - these are self-explanatory. (March 22, 1943.)



(M) Form 2614j, Ward Physician's Progress and Treatment Record - Penned notations will daily be entered relative to patients of all clinical types (that is, tuberculous, neuropsychiatric, general medical or surgical) whose conditions are acute. For patients whose condition is chronic and fairly static, notations of progress will be made at appropriate intervals, to be determined by the chief medical officer, clinical director, or chief of service. When there is no noteworthy change of condition, the entry "unchanged" will suffice. The progress notes, in general, should record, concisely, the physical findings and symptoms (if reexamination is made), with comment as to improvement or retrogression of the condition.

Treatment notations must be clear and full. Oral orders may be given a nurse in an emergency, but must afterward be recorded by the ward physician. Orders which are to be continued for fairly long periods (e.g., tonic or sedative mixtures) must be checked weekly [to determine whether they are to be continued or discontinued. If they are to be continued, they will be rewritten and dated. If they are to be discontinued, the notation "stop" will be entered, with date, opposite the order]. Medicine to be given in occasional doses (pro re nata) will be ordered on Form 2614j, will be supervised in its administration, and will be ordered discontinued as soon as necessity for its continuance no longer exists. Designated hours of outdoor exercise prescribed for ambulant patients with chronic disorders will be recorded, as will passes. The attention of the nurse in charge will be directed to those entries, so that the hour of return of these patients to the ward may be observed. Consultation with superiors will be recorded by the ward physician, with entry of day and hour. [Orders for mechanical restraint or seclusion will be recorded in careful detail as to type of restraint and duration of restraint or seclusion.]

Occupational therapy activities on wards only will be entered on this form (see (O) as to use of Form 2614-1, Occupational Therapy).

When an ambulant patient is referred to a clinic (e.g., eye, ear, nose and throat) [or to a laboratory (e.g., X-ray) for a succession of treatments, the physician in the clinic or laboratory will introduce a Form 2614j, for record of his initial treatment, and will keep that form (or any other like forms that may be brought into use after the initial form is full) for notations of findings, type of treatment, progress of patient, etc., until the course of treatments have ended. At that point, such form or forms 2614j as have been used in the clinic or laboratory will be forwarded for inclusion in the patient's clinical records. Upon the final form will be entered "treatment completed," with date, followed by the name of the physician who gave the succession of treatments.]

An officer of the day will enter upon the current sheet of Form 2614j any treatment he orders in the absence of the ward physician. Especial care will be taken to set down the dosage and hour of administration of any narcotic or other potent drug that is given.

When a sheet of Form 2614j has been filled, the ward physician will enter "Carried forward" at the foot, number in sequence the next sheet, and transpose to it those treatment orders which are to be continued.

Except to initial the ward physician's treatment orders for alcoholics and narcotics, a nurse will make no entries on Form 2614j. (December 20, 1943.)

(Paragraph 6102 continued.)



(N) Form 2614k, Nurse's Progress and Treatment Record - The notations on this form will be neat, legible and sufficiently full. Required entries are indicated by the captions of the columns, on both sides of the form. Care will be taken to record that the urinary bladder of patients scheduled for surgical operation had been evacuated prior to the departure of those patients from the ward; the manner of evacuation, voluntary voiding or catheterization, will be noted. The performance of other duties incident to preparing patients for operation, as outlined in surgical service, will be recorded. The administration of medicines will be entered after they are given. No medicine or other form of treatment will be administered without order therefor from the ward physician or other staff member. Oral orders can be taken and executed in emergency, but the ward physician will be required subsequently to record such orders. A physician's orders for alcoholics or narcotics, on Form 2614j, will be initialed by the nurse. Material changes in the condition of patients - the occurrence of convulsions, hemorrhage, delirium, accidents or injuries - will be recorded with sufficient fulness, with the time stated.

(O) Form 2614-l, Occupational Therapy - Directions for execution of this form appear at its top. When a patient is assigned to occupational therapy on a ward, this form will not be executed but, instead, the notation "Occupational therapy detail, ward only" will be made on Form 2614j, by the ward physician. If, however, such patient be assigned to a project in addition to ward activities, Form 2614-l will then be executed, and progress in such other project will be entered thereon.

(P) Form 2614m, Physical Therapy - Chief medical officers or clinical directors will instruct ward physicians that entries of physical therapy must be kept full and current; and that the ward physician, subject to coordination with the physician in charge of physical therapy, and under general supervision of the chief of medical or surgical service, will be responsible for the prescriptions and direction of physical therapy of patients under his care. Such prescriptions will be written in detail. Ward physicians will freely consult the physician in charge of physical therapy as to such prescriptions; and also will be required by the chief medical officer or clinical director to familiarize themselves with the current principles and practices of physical therapy.

The entries will consist of the diagnosis in full, the condition to receive treatment, the part or parts to be treated, and the character of the treatment, followed by signature of the prescribing physician and the physician in charge of physical therapy. The form so completed will be routed to the chief aide, physical therapy. Should immediate treatment be needed for an acute condition or in an emergency, an oral prescription may be accepted by that aide, pending confirmation by a completed Form 2614m. The aide who administers the treatment will fill in the dates, with his or her initials, upon the form, which will then be routed to the chief aide, for relay to the clinical records on the ward. Continuance and discontinuance of physical therapy, like its initiation, will be upon order of the prescribing physician. At the beginning of each month, Form 2614m will be referred to that physician who, with such notations as are necessary, will return it to the chief aide, through the physician in charge of physical therapy.

One sheet of Form 2614m can be continued in use for from two to three months. Unused spaces upon it can be utilized for entries of continuance of treatments in those spaces directly above, with dates for new months.

(Q) Form 2614n, n-1, n-2, Post-Mortem Record - If a full autopsy has been performed, the entries on this form will begin with the first term under "External



examination", and complete details will be recorded before entries under "Internal examinations" are taken up. If some body part or organ only is subjected to post-mortem examination, that fact will be recorded. For extension of data that, for lack of space, cannot be recorded under any caption on this form, the back of the form may be used or, if necessary, plain white sheets may be added. If added sheets are used, each must be numbered in sequence, and bear the name in full, C-number and register number of the deceased patient, with date of his death.

(R) Form 2614p, Dental Record - The entries required are fully indicated on this form. After completion of the entries of the examination by the dental officer, the chief dental officer will prescribe the treatment required as adjunct or auxiliary treatment of the patient's basic disorder, and submit it to the ward physician for a determination as to whether the patient's physical condition is such as to permit of rendering the indicated treatment. The reverse side of the form provides space for recording treatment as rendered from day to day. (March 22, 1943.)

(S) Form 2614q, Report of Electrocardiogram - The entries to be made are indicated by the captions on this form. The mounted tracings are to be stapled to the completed Form 2614q, for the clinical record. [A single type of mount for electrocardiographic films (buff color, with time and amplitude lines, accommodating four tracings or leads), is available upon standing contracts. For mounting of bromide paper tracings, single sheets of paper, buff color, of proper thickness and letter-size, affording sufficient space for brief identifying data, will be used, to which the tracings will be stapled.] (December 20, 1943.)

(T) Form 2614r, Anti-Syphilitic Treatments - This form is self-explanatory as to the notations it should carry.

(U) Form 2614s, Electroencephalography - This form is for use in the facility at Northport, or at any other station in which electroencephalographic apparatus may be installed.

(V) Form 2614t, Electric Shock Treatment - For use at stations where this therapy is available. The captions are self-explanatory. (March 22, 1943.)

6103. CUSTODY OF CLINICAL RECORDS ON WARDS.--(A) As soon as the Forms 2614b and c, are completed on the reception ward, they will be combined by the clinical clerk's office with the Form 2614a, Brief (the upper third of which will have been filled in, as provided in R. & P. 6102 (B)), placed in a folder as described in R. & P. 6101 (B), and returned to the reception ward. As the physical and laboratory examinations are finished they will be recorded on the appropriate forms of the 2614 series, and added to the completed reports, as will progress and treatment notes, if treatment be begun on the reception ward. When, in emergency, admission is made directly to a treatment ward instead of the reception service, the same course will be there followed. When a patient is transferred from the reception service to a treatment ward, his entire clinical record, as developed, will be transferred with him. (March 22, 1943.)

(B) [In facilities primarily for neuropsychiatric patients, the ward physician, after acquainting himself with the history, examinations, etc., developed on the reception ward, will return the clinical records file to the clinical clerk. Thereafter, the only clinical records that will be kept on wards of such facilities will be the current Forms 2614e, f, j and k. Those will be combed monthly, and all completed forms, not needed, will be arranged chronologically and sent to the clinical clerk for filing with other clinical records of the patients concerned. In facilities which, while not primarily neuropsychiatric, have a unit of considerable bed capacity for such patients, the clinical records will be handled as provided for neuropsychiatric facilities.



In facilities for general medical or surgical or for tuberculous patients, the clinical records forwarded from a reception ward will be kept on treatment wards. These will be combed fortnightly; and sheets not needed will be sent, assembled in chronological order, to the clinical clerk, for filing in identified manila folders as temporarily inactive records, pending disposition of the patients concerned.] (December 20, 1943.)

(C) Clinical records kept on wards will be under lock and key when not in use. In transfers of patients to other wards, these records will be carried by an attendant or messenger. Patients will never be allowed access to clinical records.

(D) Upon discharge, interfacility transfer, transfer from hospital to barracks at the same facility, or death, the ward physician will complete the notations as provided in R. & P. 6102, assemble all clinical records of the patient that remain on the ward, and send them, inclosed in the original folder, to the clinical clerk. (March 22, 1943.)

6104. CUSTODY AND CIRCULATION OF RECORDS BY THE CLINICAL CLERK.--(A) The clinical records maintained by the clinical clerk will be of active and inactive classes. The active records will pertain to patients receiving hospital treatment, and will consist of the surplus Forms 2614 series which are cleared from wards, as directed in R. & P. 6103 (B). Upon receipt of the first instalment of such records from wards, the clinical clerk will prepare a manila folder, corresponding to the original folder prepared for the reception ward (see R. & P. 6101 (B)), for each patient concerned, and these folders, with "Temporarily inactive" stamped or typed on the front, will be filed numerically, in sequence of register numbers. Upon ultimate disposition of patients these temporarily inactive folders will be made a part of the essentially inactive clinical records.

(B) Inactive clinical records will relate to patients who have died, been discharged, transferred to another facility, or returned from hospital to barracks at the same facility. Upon any such ultimate disposition of a patient, all clinical records pertaining to his case will be assembled and sent without delay to the clinical clerk, who will hold them for the period - not to exceed 30 days - requisite to complete any pending action (e.g., completion of post-mortem findings, Form 2614n, or of Form 2545 or 2593, closing out of correspondence, disposal of personal effects, etc.). These records will then be consolidated with the temporarily inactive Forms 2614 which had previously been cleared from wards (see (A)), and with such other clinical records as represent former episodes of hospital treatment of the patient. The complete inactive clinical records thus assembled will thereupon be stored under that hospital register number which had been most recently assigned. Upon readmission of the beneficiary, such consolidated file will be reviewed and digested, and sufficient pertinent data will be transposed therefrom to bridge over the history up to the present admission. This done, the consolidated file covering previous episodes of hospital treatment will be replaced in storage, and a new series of clinical records will be inaugurated for the patient in the reception ward.

(C) Clinical records will be subject to circulation when called for by a ward or clinic physician. When such requests are received, the clinical clerk will execute and retain a charge card, Form 3025, upon which will be entered the identification of the file, by name and register number, date of withdrawal, and name of the physician who requested the file. That physician will be responsible for the custody of such file, and its return in a complete, neat condition. Should he find



it necessary to transfer that file to another physician, he will execute a Recharge Slip, Form 7203, and route it promptly to the clinical clerk, so that such transfer may be recorded. Once a month, the clinical clerk will check the charge and recharge slips and will recall all clinical files that have been out for over thirty days, subject to their reissue if they are still wanted for reference. (March 22, 1943.)

6105. STORAGE OF INACTIVE CLINICAL RECORDS.--(A) Such metal shelving or wooden storage boxes as are installed will be continued in use for storage of inactive clinical records, but wooden shelving only will hereafter be used for any extension of such storage.

(B) The surplus clinical records pertaining to patients under treatment, which are cleared from the wards to the clinical clerk, will, after jacketing as provided in R. & P. 6104 (A), be stored on wooden shelves, filed numerically in sequence of hospital register numbers. The space allotted for storage of these "temporarily inactive" records should be separate from that used for essentially inactive clinical records. Ready accessibility of these records must be assured, as their recall to wards, for reference, may be expected.

(C) The essentially inactive clinical records will be arranged on shelving just as for the temporarily inactive records, filed numerically in sequence of hospital register numbers. See R. & P. 6104 (B) as to consolidation of these records, and their consultation upon readmission of patients concerned. (March 22, 1943.)

6106. [TRANSFER OF CLINICAL RECORDS AND FACILITY CORRESPONDENCE FILES.--(A) Clinical records of living beneficiaries will not be transferred from the facility at which they were prepared, except (1) in closure of the facility; (2) in transfers en bloc of patients for prolonged hospitalization at another facility; and (3) when requested by the Department of Justice for use in Government insurance suits. The clinical records related to a deceased veteran will be supplied to the rating agency having jurisdiction in the adjudication of a claim for death benefits, provided that request therefor be made by the director of the service involved in central office, or by the adjudication officer of a field station. After such adjudication, these clinical records are to be returned to the facility which had forwarded them, where they will be placed in inactive storage.

(B) Upon the death of an ex-member of the armed forces in a facility under the direct and exclusive jurisdiction of the Veterans Administration, his concluded facility correspondence file, a copy of his death certificate, and any other related records (except clinical records, unless requested as provided in (A)) will be forwarded promptly to central office or to the field office which has jurisdiction over the claim for death benefit in the case. When contract undertaking services were not utilized, or burial items were not supplied from stock, a statement of such circumstances, prepared and signed by the supply officer, will accompany the records so transferred.] (March 23, 1944.)

(C) The clinical records of beneficiaries of the Veterans Administration who have been hospitalized subsequent to their discharge from military service under the authority of the Veterans Administration in any of the army general hospitals listed in R. & P. 797 (B) and who have died in such hospitals will be forwarded by the commanding officer to the central office of the Veterans Administration in accordance with existing procedure. If any such clinical record is required in the adjudication of a claim it will be requested from the general records division, office of chief clerk. The clinical records of beneficiaries of the Veterans Administration, as described above, who have died in a U. S. Naval Hospital, in a U. S. Public Health Service Hospital, in a U. S. Marine Hospital, or in a State, county, or civilian



hospital, will not be forwarded to the Veterans Administration except upon request therefor. If such clinical records are essential to the adjudication of a claim for death benefits, the medical director, in central office cases, or the manager, in field station cases, will obtain the clinical records or a suitable copy or abstract thereof, upon request of the adjudicating agency concerned.

(D) Abstracts of the clinical records of one facility may be supplied upon request of the chief medical officer or clinical director of another facility.

(E) Physicians desiring to utilize the clinical records of a deceased patient in preparation of articles for publication, may be permitted by the chief medical officer or clinical director to abstract the necessary data before the records are forwarded, provided this is done without delay.

(F) For furnishing clinical records to the Department of Justice, see R. & P. 798. For disposition of clinical records of facilities which have been closed see R. & P. 797 (A) and (C). For clinical records of Veterans Administration beneficiaries from army general hospitals see R. & P. 797 (B). (December 20, 1943.)

6107. CLINICAL RECORDS KEY FILE.--(A) This file, for location of individual clinical records and for collection of such records as related to all like cases of disease or injury which had previously been treated in a facility, will have these three components:

- (1) Forms 2593, Record of Hospitalization or Domiciliary Care (station copies, green).
- (2) Forms 2580, Index to Register of Patients.
- (3) Plain 8 X 5 Cards, Index to Diseases. (March 22, 1943.)

(B) The Form 2593 part of this key file will be divided into active and inactive sections. The active section, arranged numerically in sequence of hospital register numbers, will consist of the cards pertaining to patients under treatment, that is, cards prepared upon admission and supplemental cards. The inactive section, also arranged numerically in sequence of hospital register numbers, will consist solely of the facility copies of complete Forms 2593, showing disposition by death, discharge, transfer to another facility or to the barracks of the same facility. When a complete Form 2593 is so added to this inactive section, the admission and supplemental cards related to the patient will be removed from the active section of the file, held for six months, and then destroyed. (December 20, 1943.)

(C) (1) The Forms 2580, Index to Register of Patients, is likewise to be divided into active and inactive sections. The inactive section will consist of Forms 2580 which pertain to patients who have died, been discharged, transferred to another facility, or to barracks at the same facility. The active section of this Form 2580 file will contain cards related to patients under hospital treatment. It will be fed from two sources: admission of patients who had not before been hospitalized at the facility; and reactivation of cards shifted from the inactive section, when a patient is readmitted who had previously been discharged or transferred.

(2) When a patient is hospitalized for the first time at the facility, the clinical clerk, will make the first entry upon a new Form 2580, introduced for such patient. That entry will consist of the date of his admission and the hospital register number assigned it. When a patient who had previously been discharged or transferred from the facility is readmitted, his Form 2580 will be taken from the inactive section and placed in the active section of this file, after the date of his readmission and his new hospital register number have been recorded upon it. A like



procedure will be observed upon every readmission of a beneficiary. The Form 2580, front and back, provides space for successive entries of dates of readmissions, dispositions and hospital register numbers assigned, and the introduction of an additional form should rarely, if ever, be required. If such necessity arises, the new card will be stapled to the filled card. Upon death, discharge, inter- or intra-facility transfer of a patient, his Form 2580 will be taken from the active section and placed in the inactive section of this file of register of patients with appropriate notations. (December 20, 1943.)

(3) This Form 2580 file, active and inactive sections, will be arranged alphabetically from the names of the patients included in it. [The forms pertaining to patients who have died will be kept in a separate compartment of the inactive section, and will be consulted for the total of deaths. No other separate "death file" will be maintained.] (March 27, 1944.)

(D) (1) The Plain 8 x 5 Cards, Index to Diseases.--These cards, to be arranged alphabetically from the names of the diseases or conditions listed, are intended, through the register numbers which are entered on them, to lead to the Forms 2593 component of the key file, which is arranged numerically in sequence of register numbers. If the Form 2593 so located does not furnish all the information wanted, the clinical records of the case can be procured from storage.

(2) The notations to be entered on these 8 x 5 cards (erroneously termed "The Pathological File") are, when the hospitalization of the patient is expected to be of short duration, to be abstracted from the data on the complete Form 2593, prepared when such patient is discharged, or is transferred, or dies. But when the period of hospitalization is expected to be prolonged, as with psychotic or tuberculous patients, or general medical or surgical patients with chronic disorders, the entries upon these cards, index to diseases, will be made after completion of physical and laboratory examinations, when a diagnosis and classification of the condition can be made; provided that revision of such entries will be effected if, when the complete Form 2593 is executed, there has been a significant change in diagnosis. The name of every disease or condition which has been found upon examination, as provided, or which appears on the complete Form 2593 (including associated diseases or conditions and secondary conditions or complications, but not including operations and causes of death) will be transcribed upon these 8 x 5 cards; except that minor diseases or conditions, such as missing teeth, non-vital teeth, dental caries, salivary calculus, gingivitis, astigmatism, presbyopia, hyperopia, deviated nasal septum, absence of tonsils, etc., need not be recorded. (December 20, 1943.)

(3) A separate card will be prepared for each disease or condition, as provided in (1), the name of the diagnosis or condition to be entered at the top of the card, followed by its code number, and with the hospital register number for the present admission entered in a vertical column at the left margin. The code number will be taken from the Nomenclature of Diseases and Conditions, for general medical and surgical diseases or injuries; and from the Manual for Medical Examiners, for pulmonary tuberculosis, psychoses and psychoneuroses, and diseases of the heart and blood vessels. As successive complete Forms 2593 are encountered which carry a diagnosis or condition or diagnoses and conditions corresponding to entries already made on an index to diseases, 8 x 5 card or cards, their hospital register numbers will be transposed to the appropriate disease card until space for such entries has been exhausted on that card, whereupon a new continuation card will be introduced, stapled to the filled card.

(Paragraph 6107 continued.)



(4) Thus, if the first Form 2593 shows diagnoses of diabetes mellitus and appendicitis, chronic, two 8 x 5 index to diseases cards will be prepared, one for each of those diagnoses. If the next Form 2593 lists either or both of those diagnoses, no new 8 x 5 card will be introduced since the card or cards already set up can take the entry or entries. But the hospital register number on such second Form 2593 will be recorded in the appropriate column on either or both of the 8 x 5 index to diseases card or cards which already have been filed.

(5) No cross-indexing according to body systems affected will be required, but the following modification is authorized with regard to diseases of the heart: an 8 x 5 card will be prepared and set up, under diseases of the heart, for each of the ten etiological classifications for which a code number is provided (see Manual for Medical Examiners). Upon the card will be entered the register number of the admission and the final three numbers of the appropriate code. For example, under diseases of the heart, a card would be prepared for coronary sclerosis as a cause of heart disease, and the entries would be:

Disease of the Heart	41 - - - -
Coronary arteriosclerosis	411 - - - -
Reg. Number 27600	Code Number 260

By referring to such card it is possible to find that patient 27600 had coronary arteriosclerosis with occlusion and myocardial insufficiency (Code Number 411260). For further information, the patient's complete Form 2593 and his clinical records may be procured. To ascertain the patient's name from the register number, the Form 2593, which is filed numerically by register numbers, will be consulted.

(6) A specimen 8 x 5 index to diseases card, when prepared properly, would appear thus:



## APPENDICITIS, ACUTE (0130)

### Register number

2,887

5,906

7,342

12,649

etc.

(March 22, 1943.)

### **CORRESPONDENCE FILES IN FACILITIES**

6108. CREATION, MAINTENANCE AND TRANSFER OF CORRESPONDENCE FILES.--(A) At every facility under direct and exclusive jurisdiction of the Veterans Administration a file, to be designated "Facility Correspondence", will be maintained for each beneficiary receiving hospital treatment or domiciliary care. Every admission, whether the applicant requests hospital treatment or domiciliary care, is made to the reception ward. If the application is for hospital treatment, and the beneficiary had not previously received hospital treatment or domiciliary care and therefore had no correspondence file made up for him, such file will be initiated in the clinical records office. Likewise, if the applicant had requested domiciliation but, upon admission to the reception ward, it is found that he needs preliminary hospital treatment, a correspondence file will be created for him in the clinical records office (if such admission is his first for either hospital treatment or domiciliary care), and that file will be transferred later with him when he is sent to barracks at the facility. If, however, upon his admission to the reception ward, it is found that such applicant for domiciliary care does not need to be held for treatment, he will be cleared from that ward to barracks as soon as it is determined that he has that degree of disability which would entitle him to such care. The correspondence file for a member so cleared will be initiated in the administrative office of the barracks.

(B) Correspondence files will be maintained in active and inactive sections. The inactive section, to be stored on wooden shelving, will relate to beneficiaries who had been discharged from hospital treatment or domiciliary care, or transferred to another facility. The active section, related to beneficiaries receiving hospital treatment or domiciliary care, will be kept in the clinical records office, for hospital patients; and for members in the administrative office of a facility with preponderance of members over patients. Correspondence will be inclosed in manila folders, the tab of which will bear the name, C-number if any, and register number of the beneficiary. The contents of these files will be neatly and chronologically arranged, fixed with Acco or similar fasteners. The files will be arranged numerically in sequence of register numbers.

(C) The contents of correspondence files will consist of letters relative to beneficiaries with replies thereto; forms of the 3101 series to support the determinations of eligibility for hospital treatment or domiciliary care which had been made; and other memoranda, reports, etc., which are not appropriately to be placed in a member's treatment file or in a patient's clinical record. To the inside of the front cover of the correspondence file will be affixed the applicant's Form P-10, his Finance Form 1170, (Designation of Person to Receive Personal Effects), etc. The Form



P-10 will show the place of residence of the applicant, and the name and address of his wife, nearest relative or guardian, and such person will ordinarily correspond to that person who, on Form 2614a, Clinical Record Brief, is to be notified in the event of an emergency. However when, in the clinical records office, the data for the upper part of the front of Form 2614a are being entered upon the admission of a patient, the name and address of the person whom the applicant specifies is to be contacted in an emergency, will be checked against the name and address on the Form P-10. If they do not correspond, a slip bearing the name and address (and telephone number, if any) of the person to be notified may be affixed to the inside of the front flap of the correspondence file.

(D) If, as in the prolonged hospital treatment of a tuberculous or psychotic patient, or prolonged residence of a domiciled member, the correspondence relating to such beneficiaries becomes too bulky for convenient filing in the active section of these files, older contents may be taken from the active folders and sent for storage, marked "temporarily inactive". Such temporary inactive material should be placed in a separate part of the storage shelves, so that it can easily be reached if desired for reference. Upon death, discharge or inter-facility transfer of the beneficiary concerned, this temporarily inactive portion of the correspondence related to him will be consolidated with the part that is active, and the whole disposed of together, as provided.

(E) When a member is transferred from barracks to hospital at the same facility, his correspondence file will be transferred with him. Upon completion of the hospitalization episode, the file will accompany the return of the member to barracks, and in it will be incorporated any correspondence relative to the beneficiary that had developed during such hospital treatment.

(F) Upon discharge of a beneficiary or his transfer to another facility his correspondence file will be closed out and sent to inactive storage, together with his closed out clinical records. Such inactive correspondence will be filed numerically by register numbers. Such correspondence files and clinical records will be fastened and stored together upon wooden shelving; but each will have its corporate identity and their contents will not be intermixed. However, if the beneficiary is being transferred to another facility, there is one exhibit in his correspondence file which will be taken out and transferred with him, viz., his Finance Form 1170, Designation of Person to Receive Personal Effects. A facility that retains the correspondence file of a beneficiary, as herein provided will comply with a request from another facility for any information contained in such closed files. Files of members going on furloughs (enforced or permitted) will remain in the active section, unless the furlough be later changed to a discharge from domiciliary care. (March 22, 1943.)

(G) Upon the death of a hospitalized or domiciled beneficiary, his concluded correspondence file will be forwarded [ ] as provided in R. & P. 6106 (B). (March 23, 1944.)

(H) When a beneficiary who had previously received hospital treatment or domiciliary care at the facility is readmitted for either hospital treatment or domiciliary care, his closed correspondence file will be procured from inactive storage and placed in the active section of correspondence files under the newly assigned registry number. (March 22, 1943.)



## TREATMENT AND TREATMENT RECORDS OF MEMBERS

6109 [(A) Domiciled beneficiaries are furnished hospitalization and out-patient treatment as necessitated and daily sick call.

(B) No formal authorization, such as Form P-10, Application, or Form 2557, Admission Card, is required in intra-facility transfer from barracks to hospital; the transfer will be recorded by a supplemental Form 2593, which will show the diagnosis, if possible. A complete Form 2593 is to be prepared and distributed as provided (see R. & P. 6097) when the hospital treatment is ended and the member is returned to barracks. The usual clinical records will be prepared for members who receive hospital treatment.

(C) When a domiciled member is for the first time provided hospitalization or out-patient treatment, or reports at sick call, a treatment file will be set up for him. This will consist of a manila folder, with the title "Members' Treatment File" stamped, typed or written in ink on the front cover, and with the beneficiary's name, C-number, if any, and register number on the tab. This file replaces the sick call record card (Form 2621, previously H-346) that had been in use.

(D) Files so introduced will thereafter be continuously and currently maintained. Notations of transfer to hospital, out-patient treatment, sick call or physical examinations will be chronologically and concisely made. The physician who renders treatment at sick call or in out-patient status will briefly but clearly record the history, symptoms, physical findings and diagnosis (tentative or determined). The therapy (medicines, with dosage and times of administration; minor surgical procedures; physiotherapy, etc.) will be added. These data will be recorded on plain white sheets each identified by the name of the member, and dates of the service rendered. When succeeding treatments are given, they will be recorded in sequence by dates. The initials of the attending physician will be appended to each such entry. Similarly, a dentist will record his findings and character of treatment he renders, and will affix his initials. When the attending physician orders a mixture that requires compounding by the pharmacist, or a narcotic, the regular prescription blank, Form 2577, will be executed. But for laxatives, mineral oil, liniments, etc., commonly dispensed at sick call, the name of the article and amount and hours of its administration will suffice as an entry. When members bring containers - pillboxes, bottles, etc.--of medicines which had previously been ordered for them, the attending physician will not routinely order refills, especially if the product be in any way habit-forming. If he determine to continue the product, he will order refill, and will record "refill" (with name and dosage) on the treatment sheet for the day, without a new prescription.

(E) Reports of physical examination of a member - such as are made to determine his fitness for a work-detail, or for enforced furlough, or at his request in claim for increased pension or disability compensation; or any specialistic or laboratory examination made while the member is in out-patient status; or that made when he is cleared through the reception ward to the barracks upon his facility admission - will be incorporated in his treatment file.

(F) When a member is sent to the hospital, his treatment file will go with him (together with his correspondence file, if it exists), so that the hospital staff may be informed as to the previous medical history and treatment, and the preparation



of the hospital clinical records be thereby facilitated. The treatment file, so transferred, will be attached to the clinical records until the hospital episode is concluded, whereupon a short summary of the hospital diagnosis, symptoms and treatment will be placed in the treatment file and that file returned to the out-patient unit.

(G) Members' treatment files will be maintained alphabetically arranged, in active and inactive sections. The active section should be maintained at the point where out-patient treatment and sick call of members are conducted. The inactive section will be created from the active (1) as disposition is made of the member by death, discharge or interfacility transfer; (2) when treatment has been discontinued; and (3) when treatment has not been rendered for six months. These inactive records will be stored on wooden shelving, as provided for inactive clinical records. Upon death of a member, his treatment file will be forwarded, together with his clinical records and correspondence file, to the office having adjudicative jurisdiction. A stored inactive record will be made active when the member is readmitted to the facility, and requires out-patient treatment or reports at sick call.] (March 22, 1943.)

6110. [CLINICAL RECORDS OFFICE.--(A) For duties of the clinical clerk, see "Outline of Duties and Responsibilities of Field Personnel".

(B) The organization of the work of the clinical records office so that its output will be at all times as current as possible is a cardinal consideration, not only because of the volume and variety of that work, but also because of the necessity for its expeditious handling. Rating boards must have typewritten reports of physical examination to adjudicate pending claims for monetary benefits; and the Forms 2593, Record of Hospitalization or Domiciliary Care, are required to be prepared and submitted within a specified period. This office is responsible for preparation of the daily census report; typing and distribution of the daily surgical operations schedule; compilation of periodic reports required by central office; maintenance of register of in-patients; typing of correspondence related to patients; typing of Physical Examination Reports, Form 2545, related to in-patients and out-patients; preparation and filing of Form P-10, Application for Hospital Treatment or Domiciliary Care and Finance Form 1170, Designation of Person to Receive Personal Effects; preparation and distribution of Form 2593, Record of Hospital Treatment or Domiciliary Care; preparation and distribution of Form 2557, Admission Card; maintenance of the clinical records key file; the assemblage, completion, filing, custody and circulation of all clinical records, - of medical files for out-patient treatment, and of correspondence files; handling of Forms 404, 505, and 653 (see R. & P. 6090-6092).

(C) To insure such direction and supervision by the clinical clerk as will maintain a current output of work, and permit of the concentration of the personnel on arrearages of any sort, all stenographers, typists and clerks engaged in preparing clinical records in wards, clinics and laboratories, and in preparing examination and treatment reports for the out-patient unit, will be centralized as much as possible in or near space assigned the clinical records office. When, however, the physical layout of the facility will not permit of such concentration of personnel without considerable structural alteration, or for any other sufficient reason, this requirement may be waived by the medical director upon recommendation, with full explanation, from the manager of the facility concerned. Also, upon instructions from a chief medical officer or clinical director, based upon definite determination of necessity therefor, a clinical clerk will detail any such personnel for detached duty with physicians on



wards, clinics or laboratories, such assignment to continue as long as the determination of need for it continues. Whenever possible, stenographers, after taking dictation from such physicians, will return to the clinical records office to type their notes; provided that, if determined necessary by a chief medical officer or clinical director, typewriters and other equipment may be left in the said detached locations. Reports of physical or laboratory examinations may be written in longhand for copying by typists, or may be dictated to stenographers or to dictaphones, for subsequent transcription.

(D) The eligibility clerk, or the clerk designated to attend to the duties prescribed for the eligibility clerk in relation to eligibility for hospital treatment or domiciliary care, furnishing of personal clothing, toilet articles, tobacco, etc., will be generally supervised by the clinical clerk at those facilities without a domiciliary set-up, and will be so located as to have ready access to Forms P-10, 404, 505, etc. At those facilities where domiciliary members predominate, the supervision and location of the eligibility clerk or clerks will be in accordance with the best judgment of the manager, and based upon the physical lay-out of the facility and the volume of the work to be performed by the clerk.] (March 22, 1943.)

6111. [DAILY CENSUS REPORT.—(A) As provided in R. & P. 6110 (B), the clinical clerk will compile each morning, upon a station form, the consolidated daily census report, from statistical data embodied in the nurses' day and night reports which are forwarded from each ward to the chief nurse, and which are, after initialing by her, to be relayed without delay to the clinical clerk.

(B) While minor variations in the consolidated daily census report may appear advisable to meet the comparative hospital capacity and the types of patients at the facility concerned, and such variations are allowable, this report will conform in general to the following specifications:

(1) It will be composed of three separate tables, captioned I, II and III, and respectively titled "Bed Supply," "Movement of patients," and "Seriously and critically ill."

(2) Table I, to show the bed supply, will have two columns, in the first of which the wards will be listed by letter or number, and in the second will be entered the bed capacity of each ward, and the number of occupied and unoccupied beds in it. The abbreviations "OC." and "UNOC." will suffice. At the foot of each column, totals will be entered. If thought necessary, a third column may be placed between the two herein described, in which may be entered "Ambulant," "Infirmary;" or the clinical classification of patients on the ward concerned, such as (Gen.), tuberculous (TB), etc. But since the types of patients on each ward will be known to the hospital personnel, such particularization is elective.

(3) Table II is to show the daily movement of the hospital population. It will have two columns. In the first will be entered the names of all patients who were admitted, who died, were discharged, transferred to another facility, or to another ward or barracks at the same facility, who left on permitted leave or left without permitted leave, or returned from leave of absence or trial visit. In the second column such movements will be entered, with use of symbols, thus: "adm." (admitted), died, "disch." (discharged), "lv." (on permitted leave), "a.w.o.l." (absent without leave), "ret. from lv." (return from permitted leave), "ret. from t. vis." (return from trial visit). If the patient had been transferred to another facility, "trans." (transferred) will suffice; but if the transfer was







an intra-facility one, then after "trans." will be entered, "to bar." (barracks), "to ward C", "to ward 3", etc., to fit the fact. At the foot of the first column will be shown the total of patients concerned. At the foot of the second will be recorded the totals of gains (admissions, returns from leave or trial visit, transfers from another facility or barracks) and losses (deaths, discharges, transfers to another facility or to barracks, absent on permitted leave, absent without leave).

(4) Table III is to show the seriously or critically ill patients. It will have three columns. In the first column will be entered the names of the patients; in the second, the ward in which they are under treatment; and in the third column, the words "serious" or "critical", respectively.

(C) Only such number of copies of the daily census report will be prepared by the clinical clerk as are actually necessary for supplying the officials who are specified to her, by the manager, chief medical officer or clinical director, as those requiring this report for proper performance of their duties. The original, to be retained by the clinical clerk, can be consulted by other employees who may at times require information on the report (see information desk).

(D) At the end of each month, these daily census reports, which will have been retained for that period by the clinical clerk, will be used to assist in the preparation of Form 2601, Monthly Report of Veterans Administration Hospitalization and Domiciliary Care, after which they may be destroyed. (May 15, 1943.)

6112. INFORMATION DESK.--(A) At a point or points in a facility where contact is made with visitors, prospective patients, etc., or telephonic inquiries are received, an employee will be stationed to supply information, direct inquirers to the unit and official where they can be attended to, and issue permits for ward visits.

(B) A directory of all patients in the facility will be maintained by an information clerk, on Form 2580, Index to Register of Patients. A card will be prepared for each hospitalized patient, showing his name in full, his home address, date of his admission and location of his ward. All such cards will be kept in a file, alphabetically arranged by surnames, permitting rapid reference when it is to be ascertained if any patient is still under hospitalization and, if so, on what ward. This directory will be revised each morning, from a copy of the consolidated daily census report, which will be supplied information clerks. A new Form 2580 will be prepared for each admission, and added to the file; and from the file will be abstracted the cards of patients who have died, been discharged or transferred to another facility. Intra-facility transfers will be recorded by change in ward locations. The abstracted cards will be destroyed.

(C) At stations where a visible index file, Acme or other type, has been in use instead of a Form 2580 file, such patented files may be continued. (May 15, 1943.)

(D) (1) PERMITS FOR WARD VISITS.--Information clerks will issue permits for ward visits. They will daily be informed by the chief medical officer or clinical director what patients are not to be visited, or visited only upon special permission from them. The copy of the daily census report furnished an information clerk will show, in table III, the patients who are seriously or critically ill; and if the chief medical officer or clinical director has not instructed as to visits to such patients, the information clerk will request those instructions.

(2) (a) In facilities for general medical or surgical or tuberculosis patients, permits for ward visits will be authorized on Veterans Administration Form 2671a, to be requisitioned from central office stock. The facility may, if so desired,



locally mimeograph on the back of Form 2671a, separate brief paragraphs of information, including the visiting days and hours of the facility, and other appropriate instructions governing the visiting rules of the facility. The permits will be held for 24 hours on the ward, to permit of any check that might be necessitated, and will then be destroyed. Nurses will scrutinize the dates of all permits, and the initials or signature of the information clerk.

(b) In facilities for neuropsychiatric patients, Form 2671, Visitor's Permit (N. P.), will be used in authorizing visits to patients. The information clerk will indicate by check marks whether the visit is to be in a ward, visitor's room, or grounds (any or all). Nurses, upon taking up these permits, will sign them to confirm the visits, and the assembled permits for the visiting day will, at its end, be sent to the information clerk. The latter, after executing Forms 2820, Visit Record, for the chief attorney, may destroy these permits. Forms 2820, Visit Record, will be retained in a manila folder for three years (the longest period for accountings to courts), whereupon they will be recommended for destruction and disposed of in accordance with approved procedure for disposal of inactive records. (April 3, 1944.)

(3) The information clerk will be satisfied as to the character of persons to be issued visiting permits; and will refuse them to applicants who are intoxicated or otherwise objectionable. Visitors having common colds or other communicable conditions will not be issued permits. No permits to visit isolation wards will be issued, and children under fifteen years may be permitted visits to sick relatives on tuberculosis wards only with the approval of the chief medical officer, clinical director or ward physician. Such officers will maintain a daily contact with information clerks, instructing carefully as to what patients are not to be visited, or visited only upon their permission. If the information clerk is in doubt about issuance of a visit permit to any applicant, the chief medical officer, clinical director or a ward physician will be asked for instructions. It is particularly important that the information clerk be advised what neuropsychiatric patients can be visited on wards or on grounds, rather than in visitors' rooms. See R. & P. 6187, Visitors to Psychotic Patients. (December 23, 1943.)

(4) Officers of ex-service organizations, who make more or less regular periodic visits to patients, may be provided a special pass, written and signed by the manager, chief medical officer or clinical director, authorizing the visits of such officers of ex-service organizations, to any patient allowed visitors, and at other than appointed hours. Each such pass will be made valid for [one year from date of issue; subject to renewal at the expiration of that validity period for another year], provided the recipient continues to hold office in his organization. Such pass will be surrendered by the holder when his tenure of office ends, will not be transferable, and may be revoked at any time for due cause. (July 27, 1945.)

6113. ADMISSION OF VISITORS TO WARDS.--Visiting days and hours will be fixed by the manager and posted in conspicuous locations, including information desks. Visiting will not be permitted at any hours other than so fixed except in special circumstances, to be determined by the chief medical officer, clinical director or officer of the day. No visitor will be permitted access to wards unless provided with a permit or special pass. Permits will be valid only for the date of issue, and for the ward or visitor's room or grounds, as checked by the information clerk. Visitors will be allowed to contact the patient named on the permit, and no other. If visitors attempt to contact other patients or to enter wards not authorized by their permits, they will courteously be informed that such privilege is not permissible; and, if they persist, a guard will be summoned to remove them. (December 23, 1943.)



6114. DUTY OF PHYSICIANS ON SUNDAYS, HOLIDAYS, AND AFTER REGULAR HOURS.--(A) [The chief medical officer or clinical director of a facility, in conjunction with chiefs of services, will determine the number of and which physicians will be required to report for duty on Sundays and holidays, to make ward rounds and render other necessary medical services. The designated physicians, insofar as possible, will be notified a week in advance of such assignment and will be alternated. Chief medical officers will similarly alternate for such duty with clinical directors or chiefs of services for that period of duty determined essential to supervise the conduct of medical activities. Any physician so assigned may be excused from further duty on such days, by the supervising superior, provided that the physician will have, in the superior's judgment, rendered all service necessary up to the time he departs, and that the officer of the day can take over from that time. Assignments of physicians for duty on Sundays and holidays as provided herein will not affect the usual tour of duty of the officer of the day. (See also constant readiness of the surgical service for emergency operations, R. & P. 6210; and stand-by laboratory personnel for emergencies, R. & P. 6212).] (September 12, 1945.)

(B) Chief medical officers and clinical directors will keep sufficient personnel subject to call after regular hours to insure adequate diagnostic and treatment service. Officers of the day will be carefully instructed as to the handling of emergency admissions during night hours, the issuance of telephonic or telegraphic authorizations for such admissions, and as to procedure in deaths of patients during night hours. They will be instructed to call any other physician whenever they need assistance during their tour of duty. (May 15, 1943.)

6115. SERVICES OF ATTENDING SPECIALISTS.--The services of attending specialists, part time or fee basis, will be used only when necessitated to supplement the work of the full-time staff of a facility. See R. & P. 9276-9278, for appointment of such attending specialists. They may be utilized to perform necessary services for patients hospitalized for treatment of a nonservice-connected disease or injury as well as for patients suffering from conditions attributable to military or naval service. Services of such specialists on a fee basis will be authorized by issue of Form 2639, Letter of Authority for Medical Services on Fee Basis, with appropriate citation under item (3), class of beneficiary, dependent upon whether the patient concerned is to be attended for a service-connected or for a nonservice-connected disease or injury. (May 15, 1943.)

6116. LEAVE OF ABSENCE FROM DUTY OF MEDICAL OR DENTAL OFFICERS.--(A) Chief medical officers, clinical directors and chiefs of services desiring leave of absence from Veterans Administration facilities when on duty will inform the manager. Other medical or dental officers of the facility will request authority for leave of absence from duty from the chief medical officers, clinical directors or chiefs of services. Permission for such leave of absence will not be granted if it will interfere with official duties. Authority for leave of absence of a medical or dental officer from the facility for a period of 24 hours or more will be granted only by the manager. For procedure in formal application for annual or sick leave, see R. & P. Personnel. (May 15, 1943.)

(B) Employees in medical activities other than medical or dental officers will obtain permission for leave of absence from the facility, during duty hours, from their administrative chiefs, or in accordance with rules made by the manager. (May 15, 1943.)



6117. MANAGER'S INFORMATION FILE OF PATIENTS.--For reference in compliance with the requirements of R. & P. 4762 (B), that remittance of patients' funds received by him from relatives or guardians shall be listed on Standard Form 1044, Schedule of Collections, and to check defective identifications of patients in correspondence, managers of facilities for neuropsychiatric patients may maintain in their office an information file of patients who are receiving such remittances. The file will consist of plain 3 x 5 cards, bearing the full names and C-numbers, if any, of the patients concerned, together with the names and addresses of the relatives or guardians who are the remitters of funds. This file can be kept current by routing over it, for transpositions or additions or removal of cards, the forms compiled in the clinical records office. A complete file of all patients in the facility will not be necessary, since many will be in receipt of institutional awards, or their comforts are taken care of by relatives, and no account to the finance officer is required for such patients. If telephone calls relative to patients not listed in this file are received, the index of register to patients on Form 2580, at the information desk (see R. & P. 6112) may be consulted and the daily census report (see R. & P. 6111 (B)) will show the seriously and critically ill patients. This manager's file will serve the purposes of the chief medical officer, clinical director or chief nurse. (December 23, 1943.)

6118. REGISTER RECORD.--The register of in-patients (see R. & P. 6110) will be kept by the clinical clerk in Standard Form No. 50177 or similar book record. Opposite the full name of every patient upon his admission will be entered the hospital register number assigned him, together with his C-number, if any, and date of admission. If desired, especially in neuropsychiatric hospitals, there may also be entered the name of the staff physician to whom the patient is assigned for examination, classification and presentation at staff conference, so that the preparation of clinical records and the submittal of reports of physical examination will not be delayed. (December 23, 1943.)

#### RECEPTION WARD

6120. ADMISSION OF BENEFICIARIES.--(A) Except in emergency, when it is judged necessary to admit a patient directly to a ward or operation suite, all beneficiaries admitted for hospital treatment or domiciliary care, as well as claimants or beneficiaries authorized hospital observation with physical examination, will be entered through the reception-outpatient service, under direction of the chief, or a physician of that service or, after regular hours, by the officer of the day. As soon as a bed is assigned each entrant to the reception ward, he will be visited by a physician of that ward, who will make such preliminary physical examination as will suffice to establish the condition of the beneficiary, and guide to any treatment needed at that time. Completion of physical examinations, including laboratory tests, will follow as promptly as possible after this initial visit.

(B) Fluidity of beds is an imperative in a reception ward: There must be a reservoir to supply incoming beneficiaries, and this is made possible only by steady clearance of occupied beds. Physical examinations, general and special, and laboratory tests will be expedited, and when completed, persons requiring treatment will



promptly be transferred to treatment wards. The cooperation of laboratory personnel will be required to this end. The following classes of bed occupants will have especially prompt clearance:

1. Applicants for domiciliary care - these will receive the preliminary physical examination, regardless of the content of the medical certificate on Form P-10. If that examination shows need for treatment before admission of such persons to barracks, they will be held on the reception ward for the required period. If they require no treatment, admission to barracks will be made without delay; completion of the examination of such beneficiaries can follow after they have been domiciled. Since the contemplated short stay of such applicants for domiciliation upon the reception ward is wholly for such determinative examination, their admission to the facility will be identified on Form 2593, Record of Hospitalization or Domiciliary care, as Dom. (Domiciliary).

2. Claimants or beneficiaries admitted for observation and examination, particularly those who are employed, so that they can resume their occupation with the least loss of salary or wages. Reports of such observation and examination should be cleared without delay to the rating board having jurisdiction.

3. Beneficiaries who need surgical operation - for hernia or other reparable conditions, - and because of that need are in danger of losing a position or are prevented from securing employment, will be recognized as presenting an economic emergency which will entitle them to preferential attention. As soon as the examination of such beneficiaries is completed upon the reception ward, they will be referred without delay to the surgical service.

4. Patients who are upon admission, or later become, seriously or critically ill before transfer to a treatment ward. It is the policy of adjudication agencies to give priority to claims for monetary benefits for such patients, including especially those whose condition seems terminal. Chiefs of reception-outpatient services will contribute to the expedited adjudication of claims for monetary benefits in such cases by preparing and submitting, as promptly as possible, reports of the physical examination of such patients. When Government insurance is involved, such report should be dispatched to the director of insurance, central office.

(C) The preliminary physical examinations made in the reception ward will include a careful search for fractures, dislocations, wounds, bruises or lacerations (especially of neuropsychiatric patients), and any evidence that the patient is under the influence of an intoxicating liquor or drug. If the admitted patient is unconscious, the possibility of skull fracture, apoplexy, uremia, diabetic coma, etc., will be investigated, and the person who accompanied him upon admission will be interrogated to develop as much history as possible. The presence of vermin on the person or clothing of beneficiaries and the existence of venereal infection or other communicable disease will receive careful attention. When any of the foregoing unusual circumstances surround admission of a beneficiary, appropriately detailed notation thereof, including statement of the measures taken (that is, emergency treatment, isolation, sterilization of clothing, etc.) will be made on the reverse of Form 2614c, Clinical Record. The prohibition of the introduction of weapons, alcoholic beverages, drugs and medicines for self-administration will have due regard. The taking over of funds, valuables and clothing of admitted beneficiaries will be in accordance with governing instructions.



(D) For each beneficiary entering the reception ward, the clinical clerk will assign a register number, and for persons determined as needing hospital treatment will have prepared Forms 2614a, b and c (Brief, Family and Personal History, History of Present Disease.) Care will be taken to record the correctly spelled surname, first and middle names of beneficiaries, as obtained from them or from persons accompanying them. It is equally important to secure the full, correct names of all relatives who may be prospective heirs, with accurate notation of their addresses (see R. & P. 6036).

(E) When a patient, in a medical emergency, is admitted directly to a treatment ward or surgical suite, instead of to the reception ward, the records prepared as called for in (D) hereof will be introduced into use on such other ward.

(F) When the physical and laboratory examinations of a patient admitted to the reception ward have not been completed before transfer of that patient to a treatment ward has been made, then the Forms 2614a, b, and c, together with such other parts of the clinical records as had been completed on the reception ward will be transferred with the patient to the treatment ward. The physician of that ward will then request the clinical clerk to supply such clinical records as had been made pertaining to any former admission or admissions of the patient to the same facility. (May 15, 1943.)

6121. EXPLAINING CONDUCT REQUIREMENTS TO BENEFICIARIES IN THE RECEPTION WARD.-- Every competent patient who is admitted to the reception ward will be informed regarding provisions relative to orderly conduct, care of Government property, grant of passes, leaves of absence, etc., and the penalties for infraction of facility discipline. A copy of the station's mimeographed rules governing these subjects will also be supplied the beneficiary. (May 15, 1943.)

#### TREATMENT WARDS

6125. WARD ROUNDS.--(A) For detailed duties of a ward physician, see "Outline of Duties and Responsibilities of Field Personnel." Ward physicians may be required to be on duty at any time and for any period within the 24 hour day, when necessity demands. The regular week day morning round of their ward, when every patient on it is to be visited, will also be made by them on alternate Sundays and holidays, as provided in R. & P. 6114. Night round of their ward will be made, especially when they are in charge of disturbed or suicidal psychotic patients, or other patients who are seriously or critically ill. At such rounds they will make any required examinations and render any treatment needed, and leave such instructions for nurses, hospital attendants, or the officer of the day, regarding such patients, as may be judged necessary. Orders will be recorded - legibly, and with clarity and sufficient fulness - on Form 2614j.

(B) Ward physicians will maintain and will require ward nurses and attendants to maintain a fair, patient and courteous attitude, without familiarity, to beneficiaries. The comfort and contentment of every patient will be a concern of ward personnel. Interruption of treatment through necessity for irregular hospital discharge will be prevented by inquiry into any evidence of dissatisfaction or unrest. If a patient is worried about some situation at home, the social worker should be asked to intervene and assist as far as possible in adjusting it. Ward personnel will be attentive to



complaints of patients regarding their medical treatment, food, etc., and the corrective action that appears needed will be taken, either upon the initiative of ward personnel, or by reference of the complaint to other officials having jurisdiction. Ward physicians will reassure any timid or obstructive patients as to the necessity for and reasonable nature of any proposed treatment measure to which objection is raised, such as surgical intervention, spinal puncture, etc. Using professional judgment, they will impart such information to a patient, regarding his condition, as will insure intelligent cooperation.

(C) That clinical classification and ward grouping of patients which conform to and facilitate modern treatment methods will require continuous attention; and indicated intra-facility transfers, to other wards more adapted for a patient with changed condition, will be effected promptly, after notification to the chief medical officer, clinical director or chief of service concerned. The latter officers will be consulted frequently, especially when a patient's condition shows a tendency to chronicity or retrogression. When a change in major diagnosis is made, the clinical clerk will be informed (station form), for preparation and submittal of a supplemental Form 2593, Record of Hospitalization and Domiciliary Care, to the budget officer and chief of statistics. The physician of a ward to which a patient is transferred will not routinely accept the transfer diagnosis, but will examine the patient; and if he concludes that the transfer was not properly made, will consult his chief of service, or the chief medical officer or clinical director.

(D) Ward physicians will prescribe the type of physical therapy that is to be rendered by physical therapy aides. (May 15, 1943.)

(E) [To prevent delay in dehospitalization that might be caused by the necessity of completing dental treatment, it is mandatory that the ward physician take prompt action on Form 2614p, Dental Record, submitted to him by the chief dental officer, for approval. Close check will be kept upon patients whose physical or mental condition forbids immediate inauguration of approved dental treatment, so that they will later be given the deferred treatment.] (December 23, 1943.)

(F) Accidents to patients will be reported, without delay, on Form 2633, in the manner provided.

(G) Ward physicians will promptly respond to calls from their ward, coming from a nurse or attendant, during regular hours. They will give the officer of the day, orally or by entry on the clinical records, such instructions pertaining to critically ill patients on their ward as will guide him in his tour of duty; and they will be prepared to proceed quickly to their ward, if called in an emergency by the officer of the day.

(H) Particular care will be taken by ward physicians to observe the procedure prescribed for acceptance and disposition of funds delivered for use of patients by relatives or friends. (May 15, 1943.)

6126. ORDER, QUIET AND CLEANLINESS OF WARDS.—(A) Order, quiet and cleanliness will be required at all times on all wards, and prompt, firm measures will be taken to correct any deficiencies in these cardinal requirements. Prescribed bedrest hours for ambulant tuberculous patients will be enforced, with due explanation of the necessity therefor.

(B) Due care of Government property on wards, both as to employees and patients, will be exacted, and any loss or willful damage of ward furniture, supplies and equipment will at once be reported to the ward physician, who will investigate the facts and report to the manager, through channels.



(C) Unnecessary noise, boisterous or disorderly conduct, abuse or disrespect to employees, profane or obscene language on wards, or in halls, toilet rooms or recreation rooms will not be tolerated. Competent persons so offending will be warned to desist at once; if they do not, action will be taken to prefer charges for infraction of discipline (see procedure therefor). Gambling of any kind is prohibited on wards, in recreation rooms or in any other part of a facility or its grounds. Card playing or other games, without stakes, may be permitted on infirmary wards by physicians thereof, and are allowable in recreation rooms. The use of personally-owned radio receiving sets may be authorized on wards, subject to these conditions: That the chief medical officer or clinical director will grant this privilege only to bedfast patients whose condition is relatively chronic, requiring prolonged hospital residence; that other patients are not disturbed by the use of such sets; and that the treatment regimen of the patient granted this privilege is in no way interrupted or interfered with thereby. If any of these conditions is not met, this privilege will not be granted or, if granted, will be revoked. Further, such set, if sold or given to any other patient by the original grantee upon his departure from the facility, will not entitle the second owner to its use on a ward, unless the conditions specified are fully met by him. Firearms or other weapons, ammunition, alcoholics or narcotics, or drugs for self-medication, if found in use by or in possession of beneficiaries will be impounded, and disciplinary action taken, as provided.

(D) Patients will be required to be clean in person and habits, have clean ward and bed clothing, and requisite toilet articles. Towels, toilet articles, articles of clothing, eating or smoking utensils in possession of or use by any patients will not be permitted to be used by his fellows. Personal clothing and other articles not actually required nor permitted on wards will be placed in storerooms. Such personal possessions as are permitted on wards will, when not in use, be kept in individual lockers. Receptacles will be provided for matches, cigarette or cigar butts or ashes, etc., and patients will be required to deposit all refuse therein, and cautioned not to throw such articles into closet bowls or urinals. Expectoration on floors or walls of wards or any other part of a facility will be absolutely forbidden. Foods will not be brought from dining rooms by patients. Foods, including fruit, candy, etc., must be delivered by visitors at the desk where they apply for ward visit permit, and foods so delivered are sent for disposition by the chief dietitian. If any such foods are smuggled into a ward, they will be confiscated by ward personnel, with explanation that special diets are interfered with by consumption of other foods. Foods so confiscated will be sent to the chief dietitian. Entire freedom of wards from flies will be preserved, and window screens will be kept in good condition. Infraction of any rules governing sanitation of wards, particularly after warning, will be met by prompt disciplinary action. (May 15, 1943.)

6127. SMOKING BY PATIENTS.--Smoking by patients will not be permitted on wards, halls, stairways, toilet rooms or any other part of facility buildings, except in such rooms as are designated for this purpose by the managers; and except as to such bed patients as are permitted to smoke by ward physicians. (May 15, 1943.)

6128. ISOLATION OF PATIENTS.--Patients with communicable diseases will be immediately isolated, and approved sanitary precautions at once taken to control spread of the disease. Employees detailed for duty on isolation wards or rooms will sleep in quarters separate from other employees. All dishes, silverware and other food containers used on isolated wards or rooms will be kept there and not returned to the



main kitchen. Diets will be delivered to the door of the isolation ward or room by personnel from the patients' mess, and will be transferred there to the ward food containers. The containers brought from the patients' mess will, upon return, be thoroughly sterilized. Patients and the personnel in charge of them, upon discharge from isolation, will be given such disinfection as is indicated, and the vacated isolation ward or room will be cleaned and disinfected. No persons other than those actually in charge of the patient will be permitted entrance to the isolation ward or room, and this prohibition will extend to other medical officers, unless they present a permit from the chief medical officer or clinical director. Physicians, nurses and attendants who have been on duty in isolation wards or rooms in attendance upon patients suffering from scarlet fever or erysipelas or other streptococcic infections will not be assigned for duty in the surgical service for at least 10 days after release from the isolation ward or room. Nasal and pharyngeal cultures will be made twice weekly from physicians, nurses and other employees on duty with cases of meningitis and diphtheria. If a positive culture be found the employee will be isolated and appropriate treatment given until three successive negative cultures are obtained. The beds of all cases of whatever character in which a disease is communicated by nasal, oral, pharyngeal or bronchial secretions will be so separated in wards by sheets or screens so as to prevent cross-infection. This will also be done in cases of pneumonia, empyema or other surgical infections. Diseases requiring isolation will include venereal infections and amebic or bacillary dysentery, though the precautions fitted for more essentially contagious conditions may be appropriately modified for these. (May 15, 1943.)

6129. TAGGING OF PATIENTS' BEDS.--All beds occupied by patients will be tagged, with Form 2596, Patient's Identification Tag, to show the ward number or letter, surname and first name, hospital register number, and home address of the patient, and the name and address of his nearest relative. (May 15, 1943.)

6130. [TERMINAL CONDITION OF PATIENTS.--(A) When their travel is not contra-indicated and their families do not object, patients whose condition is determined as terminal will be discharged to their homes or that suitable facility which is nearest their home, to allow them to spend the remainder of their lives in the company of relatives and friends. See R. & P. R-6100 (D) (2) as to approval by medical director of travel exceeding the distance covered in proceeding to the facility. If such patient has no home or friends willing to receive him, or if travel would jeopardize his life, a special nurse or attendant will be detailed for duty with him, he will be kept under personal supervision of the ward physician, and a private room will be provided for him when death is imminent.] (December 23, 1943.)

(B) Upon the death of a patient, his identification tag will be detached from the bed, by the ward physician or officer of the day, and affixed securely to the right wrist of the body, there to remain until it is ready for shipment or local burial. The ward physician or officer of the day will supervise the removal of the body to the morgue; and will assume custody, without delay, of any funds, valuables or other personal effects that had been in possession of the deceased patient on the ward. Delivery of such funds, valuables and other effects will be made by such medical officer in the manner provided. (See R. & P. R-4803.) (May 15, 1943.)

6131. REQUESTS FOR CONSULTATIONS.--Clinical directors or chief medical officers will instruct physicians and dentists of their staffs relative to arrangements for consultation with personnel of other services, or with attending specialists of the



facility concerned. The diagnoses made and treatment recommended by such consultants will be duly recorded, over the consultant's signature, in the patients' clinical records. (May 15, 1943.)

6132. ESTABLISHMENT OF IDENTITY OF PATIENTS REFERRED FROM WARDS TO CLINICS OR OPERATING ROOMS.—The identity of a patient who is being sent from a ward to a surgical operating room or clinic or laboratory, for either major or minor surgical intervention, or for spinal puncture, intravenous medication, etc., will in every case be unmistakably established before such patient leaves the ward. The hospital attendant, the nurse in charge and the physician of the ward will each identify such patient; and the ward physician will personally conduct or turn the patient over to an attendant to be conducted to the operating room, clinic or laboratory where the service is to be rendered. That attendant will also deliver the Form 2813, Authorization for Surgical Procedure, signed by ward personnel to the physician who is to operate, etc., and after signature by him, the form will be returned for filing in the patient's clinical records. Failure to observe these precautions will be cause for disciplinary action. This requirement will not apply in the reference of patients to the dental or artificial pneumothorax clinic, [and will not be required in a series of the same treatments (such as repeats of intravenous medication, etc.) after the initial treatment was given with due identification of the patients]. (December 23, 1943.)

6133. CUSTODY OF DRUGS ON WARDS.—Phenol, mercuric chloride in tablets or solution, all other toxic or potent drugs in whatever form, alcohol, whiskey, brandy, etc., and narcotics will be kept in a medicine cabinet the key of which will be in possession of the nurse in charge of the ward. Specially designed blue poison bottles will be used for poisonous drugs. Containers with stained, torn or illegible labels will be sent to the pharmacy, for relabeling. Poisonous medicines will be segregated in the medicine cabinet. Nurses will carefully note the color and odor of medicines, and will twice read the directions, before administering them; and if in any doubt, will consult the ward physician. (May 15, 1943.)

6134. DISPOSITION OF MEDICINES RECEIVED FROM OUTSIDE SOURCES BY PATIENTS.—See prevention of introduction of medicines for self-administration. When a patient, after hospital admission, receives a medicine by mail, express or personal delivery from a visitor, he will be required to surrender it. If the patient be incompetent, his guardian or nearest relative will be asked to state whether the medicine shall be destroyed at the facility or shipped, express, collect; it will be added that if instruction is not received within one month, destruction will be proceeded with. If the patient be competent, the medicine will be delivered to him upon discharge and, if he had been instructed upon his admission that such medicines were not permitted, he will, for violation of hospital discipline, be penalized as provided. If a competent patient refuses to surrender such preparation, the penalty will be discharge for obstructing treatment. (May 15, 1943.)

6135. ISSUE AND CONSERVATION OF CLINICAL THERMOMETERS.—(A) Continuous care will be exercised to prevent breakage or loss of clinical thermometers in use on wards or in clinics. No clinical thermometers will be supplied patients for personal possession. Requisitions for clinical thermometers will be prepared by the chief nurse. The chief medical officer or clinical director will approve and initial such requisitions and route them to the supply officer only after careful scrutiny of the number called for. If the requisition appears excessive as compared with previous requisitions and with consideration of patient population, the chief medical officer



or clinical director will require a satisfactory explanation from the chief nurse before approving the requisition.

(B) The supply officer will issue requisitioned clinical thermometers to the chief nurse, who will distribute them to nurses in charge of wards or clinics. Nurses so receiving these thermometers will be held responsible for their careful use by personnel under their supervision. Nurses in charge will turn in broken or unserviceable clinical thermometers to the chief nurse to be exchanged for new ones, and the chief nurse will require an explanation from each nurse in charge for loss or breakage of thermometers that had been supplied. The chief nurse will maintain a record of the totals of clinical thermometers supplied each month to each ward or clinic, with the number of thermometers turned in for exchange as broken or otherwise unserviceable, or reported as lost, on each ward or clinic for the month. This monthly record will be gone over upon its completion by the chief medical officer or clinical director with the chief nurse, and if undue loss or breakage is shown by any ward or clinic, the nurse in charge thereof will be instructed to caution personnel under her direction to observe better care of the thermometers.

(C) If clinical thermometers are lost or broken through clear carelessness or intentional mishandling of a competent patient, the circumstance will be fully reported to the manager, through channels; and the manager may, without convening a board of discipline, inflict, for a first offense, one of the minor penalties provided for absence without leave. If there be a repetition of the offense, the manager will refer the charge to a board of discipline, who may recommend discharge of the offender from the facility, for destruction of Government property. (May 15, 1943.)

6136. PRECAUTIONS IN APPLYING HOT-WATER BAGS.--Ward personnel will always keep in mind the prevention of burns from hot-water bags, especially in unconscious or mentally dull patients, or those having area of anesthesia. Sensibility to heat differs considerably; age and disease may lower the threshold of its tolerance. The temperature of the water that is to be used to fill a hot-water bag will be taken with a dairy thermometer, in a pitcher. A maximum of 140° F for more robust adults, and 120° F for old and weak patients will be safe enough and will meet the indications in most cases. A filled bag must always be inclosed in a cover and, before applying it to the patient, the covered bag will be brought into contact with the inner side of the forearm of the nurse or attendant, to be sure that its heat is not excessive. From time to time patients to whom hot-water bags have been applied will be visited by the nurse or attendant, to note if there is any complaint of discomfort from contact of the bag. A patient who drops off to sleep after application of a hot-water bag will be given quiet inspection of the area of application, to be assured that no ill-effects have occurred or will occur. The application of hot-water bags to unconscious, semi-conscious or mentally dilapidated patients, or over areas of anesthesia, will be made only upon the order and subject to the supervision of the ward physician. In such cases, the covering of the hot-water bag may be reinforced, or the bag placed upon an intermediate blanket. (May 15, 1943.)

6137. PREVENTION OF EXPLOSIONS IN OXYGEN TENTS.--Absolutely no smoking, and no flame or device or wiring that might cause ignition will be permitted in or near an oxygen tent during administration of that gas. Since, in high altitudes especially, static electricity can be generated by the rubbing of woolen blankets used on a patient in an oxygen tent, precautions against ignition of any material in the presence



of the oxygen will be taken by grounding each woolen blanket, through a copper plate firmly attached thereto and connected, by a copper wire lead, to a radiator. The wire lead must make perfect metallic contact at the radiator and at the plate. This precaution need not be observed when using cotton blankets, which will always preferably be employed. (May 15, 1943.)

6138. CONSENT TO SURGICAL AND OTHER TREATMENT.--(A)(1) Surgical Operations - The written consent of a competent adult will be obtained before a surgical operation is performed upon him.

(2) The written consent of a guardian or nearest relative will be obtained before performance of a surgical operation upon an incompetent or unconscious patient or upon a minor, except as to a minor member of the armed forces receiving hospital treatment upon authorization of an Army or Navy officer.

(3) Such consent, recorded on Form 2813, Authorization for Surgical Procedure, will be filed in the clinical records of the patient. If operation is refused, the notation "operation refused" will be entered on that form, for like filing. When consent is being requested, the necessity for the operation, and assurance that it is in the interest of the patient and his family, and will be performed with every possible care and consideration, will be given to the patient or his representative.

(4) In acute emergencies where effort to get in touch with guardians or relatives has failed, and further delay would jeopardize life, operation may be performed upon authority of the manager. In such cases, a memorandum of the circumstances, signed by the manager, will be placed in the clinical records of the patient.

(B) (1) Spinal puncture, whether for diagnosis or treatment, will require (except as provided in (B) (2)) written consent of the patient, if he be mentally competent; or of his guardian or nearest relative, if he be mentally incompetent or unconscious. Such consent will be recorded by signature of the patient, or his guardian, or nearest relative to Form 2813, Authorization for Surgical Procedure. That returned form will be filed in the clinical records of the patient. If the procedure be declined, the certification "spinal puncture refused" will be entered before the form is so filed. Explanation of the necessity for the procedure, and occurrences of its common employment and comparative safety will be made to a competent patient or to the guardian or nearest relative of an incompetent patient. Refusal of request for spinal puncture will also be recorded on any Report of Physical Examination, Form 2545, that is submitted to a rating board in relation to the patient concerned.

(2) If a psychotic patient has no guardian or relative of record or who could be reached, and it is the opinion of the chief medical officer or clinical director that spinal puncture is necessitated, a statement of the circumstances will be made to the medical director, who will instruct the manager as to what action is to be taken. (May 15, 1943.)

(C) OTHER DIAGNOSTIC OR THERAPY MEASURES.--[Shock therapy (electric, insulin) will require consent of the nearest relative or guardian. The administration of insulin shock will require that each patient proposed for the treatment shall have been selected as being without any physical condition which would contraindicate the procedure; that the treatment will be given by a physician trained in the therapy; that the facility has a properly equipped and adequately staffed unit for the treatment; that the patient is under age 45 and his psychosis is of less than five years duration. Use of metrazol is not permitted for shock therapy (its proper use in other conditions - circulatory collapse, acute barbiturate poisoning - may be continued). Other special diagnostic procedures (cystoscopy, injection of lipiodol),



renal permeability tests, etc.) or therapeutic measures (such as malaria inoculations for paresis, diathermy, intravenous injection of arsenicals; intramuscular injections, anti-syphilitic or for other purposes; radium or X-ray therapy, etc.) will not require prior consent, but the cooperation of competent patients will be secured by a reassuring explanation of the necessity for the treatments, its relative safety and minor inconvenience, its everyday employment, and the care which will be exercised, etc.] (December 23, 1943.)

(D) Obstruction or refusal of diagnostic or treatment measures by competent patients will be recorded upon their clinical records and upon any Report of Physical Examination, Form 2545, that is submitted to a disability rating board. Consideration will also be given to a discharge against medical advice, provided the condition of the patient permits of that action. (May 15, 1943.)

6139. ACCESSIBLE SUPPLY OF EMERGENCY MEDICINES.—(A) A small but sufficient supply of biological products, for prompt procurement by wards or the out-patient unit, will be kept, refrigerated, in the clinical laboratory, under custody of the chief, laboratory service, and personnel designated by him. The chief medical officer or clinical director will decide what kinds and quantities of such biological products shall be so stored, but the following would be appropriate inclusions: diphtheria antitoxin, normal horse serum, tetanus antitoxin, smallpox vaccine, typhoid vaccine, anti-pneumococcus serum, and anti-meningococcus serum.

(B) In the medicine cabinets on wards will be kept such drugs as, in the judgment of the chief medical officer or clinical director, should be quickly accessible in emergencies, such as hemorrhages.

(C) The stock of biological products in the clinical laboratory and medicine cabinets on wards must be made accessible to the officer of the day, and keys to accomplish such access during other than regular hours will be supplied the officer of the day. (May 15, 1943.)

6140. BLOOD TRANSFUSION.—(A) Pursuant to Public No. 196, 77th Congress, any person, whether or not in the employ (military or civilian) of the United States, who furnishes blood for transfusion into a patient receiving entitled treatment at Government expense in a Veterans Administration facility (as defined in Veterans Regulation No. 10 (b), paragraph XIX); or who furnishes blood for blood banks or for other scientific and research purposes incident to the treatment and care of entitled beneficiaries, will be paid for blood so supplied at rates specified in the Schedule of Fees, Veterans Administration; provided that, for a single transfusion, not more than \$50 can be paid and less than that maximum may be paid if the rates prevailing in the community make a lower payment possible; and further provided that no payment will be made for blood withdrawn to determine the type of donor, nor for blood withdrawn for the benefit of the person from whom it is withdrawn. See also R. & P. 4300.

(B) The provisions of (A) are applicable not only to patients hospitalized under R. & P. R-6047, but to beneficiaries of other Federal agencies, such as the United States Employees Compensation Commission, Army, Navy, etc. Donors as specified in (A) may be used for blood transfusion of Canadian or British Imperial pensioners receiving authorized treatment, or for civilians hospitalized under the authority for emergency admission.

(C) An offer from a donor to provide blood without payment may be accepted; provided that a record of the voluntary service be made in accordance with subparagraph (I) hereof, and that the volunteer consents to the full preliminary examination required under (G) hereof.



(D) A list of blood donors will be kept in the clinical laboratory of each facility, on a file of 3 X 5 cards, alphabetically arranged. Each card will show the name and address of the donor; whether he is a donor solely for the facility concerned or also is registered by other hospitals or agencies; the date of his most recent physical examination; and the type of his blood, O, A, B or AB, according to the classification of the National Research Council. The list of donors will be checked monthly and any necessary revisions made in the cards.

(E) Before a donor is listed he will be given a thorough physical and laboratory examination to exclude persons affected with syphilis, tuberculosis, malaria, epilepsy, hypersensitiveness, hypertension, anemia and communicable diseases in general. A complement fixation test or Kahn precipitation test or both will be done for each prospective donor; and, if found positive, suggestive positive or doubtful, or if there is any history of or clinical evidence of syphilis, such prospective donor will not be accepted and listed.

(F) Besides this initial physical and serological examination of a prospective donor before acceptance and listing, donors accepted will be so reexamined every six months after they are listed, unless the donor concerned has, within that period, been so examined by another hospital or agency and report of examination is obtained from such other hospital or agency in confirmation.



(G) Finally, when the services of a donor are required, he will then be examined to exclude the conditions mentioned in subparagraph (E); will be questioned carefully as to syphilitic infection; and will, when time allows, be given a Wassermann blood test. If the time is not allowable for this, because of an emergency, then a Kahn precipitation test will be made to exclude the presence of syphilis.

(H) Direct blood matching will be done in each patient requiring transfusion, in accordance with instructions in Clinical Bulletin No. 26, Veterans Administration.

(I) Requests from wards for donors will be [made on Form 2837, Blood Transfusion, by ward physicians, addressed to the chief, laboratory service. The first entry on Form 2837 will state the name, ward and bed number of the patient, and the place, date and hour the donor is to appear. The chief, laboratory service or employee acting for him will contact the donor, arrange his physical examination, make the serological tests, and type the patient's blood against the donor's. The physician who examined the donor, and the laboratorian who made the serological tests and the typing, will then execute the certificates of the examining physician and the laboratorian, respectively, on Form 2837. The donor will then be sent to the place and at the hour appointed, and will carry the Form 2837 so executed. If, despite the certifications on Form 2837, the physician who is to perform the transfusion decides to reject the donor, he will enter "donor not used" on Form 2837, and send the donor, with the form, back to the chief, laboratory service or the laboratorian acting for him. Otherwise the transfusion will be begun and upon its completion, the physician making it will execute his certification on Form 2837 and send the form to the chief, laboratory service or the laboratorian acting in his absence, who will record upon the form, above his signature, the amount due the donor under the Schedule of Fees, Veterans Administration. The form will then be placed in the clinical records of the patient concerned.]

(J) No blood will be withdrawn from a donor for a blood bank, or for scientific or research purposes, without prior consent of the medical director.

[(K) Transfusion of blood is a surgical procedure, the responsibility for which will be assumed by the chief, surgical service. All transfusions will be performed by physicians attached to the surgical service. If the patient to be transfused is on a medical ward, his ward physician, at the same time that he sends request for a blood donor to the chief, laboratory service, will ask the chief, surgical service to detail a physician of that service to perform the transfusion upon the ward and at the time appointed.]

The physician making the transfusion will remain with the patient until its completion, and will then execute his certification on Form 2837. If the patient shows any untoward reaction, he will take appropriate measures, and will record such circumstances on the Form 2614g of the patient's clinical records.

(L) If a blood transfusion be required in other than the regular hours, the officer of the day will contact the chief, laboratory service, or his representative, for procurement of the donor, and will summon a physician of the surgical service to perform the transfusion.] (May 15, 1943.)

[6141 - 6144 canceled May 15, 1943.]







## TUBERCULOUS PATIENTS

6145. [DAILY REST PERIODS FOR TUBERCULOUS PATIENTS.--The chief medical officer or clinical director will issue a standing order appointing the morning and afternoon hours of daily rest periods for the various types of tuberculous patients, specifying in what periods mental inactivity and vocal silence are to be observed, as well as rest in bed. Ward physicians and nurses will require full compliance of patients with daily rest period instructions. Patients will remove shoes and street clothing during these periods, and all unnecessary movements of employees about the wards will be avoided. Occupational therapy aides and librarians will cooperate in securing the execution of station orders forbidding occupational therapy or reading during rest periods. Infractions of instructions regarding observance of daily rest periods by patients or employees will be reported to the chief medical officer or clinical director for appropriate action. Offending employees will be admonished and action taken against offending patients in accordance with provisions governing hospital discipline.] (May 15, 1943.)

6146. [GRADUATED EXERCISES FOR TUBERCULOUS PATIENTS.--The chief medical officer or the clinical director will issue instructions to the facility staff covering graduated exercises for patients of the appropriate clinical types. Upon Form 2614d-1, Clinical Record - Initial Examination of Chest, notations will be made of the hours in the month devoted to graduated exercises and occupational therapy, specifying the kinds, periods, and by what physician supervised. This information is of particular value in suits on Government insurance.] (May 15, 1943.)

[6147. LECTURES TO TUBERCULOUS PATIENTS.--The chief medical officer or clinical director will prepare an outline of lectures to tuberculous patients, for instructional purposes. These lectures may be given at such times as are best suited. A suggested outline of such lectures is as follows: Incidence of tuberculosis in the white and other races; immunity and how acquired; influence of heredity; infections in childhood and later life; bacteriology of the tubercle bacillus; clinical types of the disease, with discussion of reparative process; personal hygiene of affected patients (bathing, care of teeth and nails, seasonal clothing); coughing, expectoration, sneezing, disposal of secretions, control of coughing; influence of climate and altitude in treatment; food in treatment; exercise - when contraindicated and when beneficial; rationale of graduated exercise; passes and leaves of absence - reasons for controlling; precautions to be taken upon leaving the facility; advantages of hospital care and treatment; duty to family, society and fellow-patients; importance of rest, explanation of absolute and relative rest periods; effects of tobacco and alcohol, dangers of dissipation; occupational therapy and its purpose; role of medicines in treatment; reactivation of the disease, measures to prevent; regular discharges and when given: discharges under R. & P. R-6065. The instruction must be intelligently devised to secure the interest and cooperation of the patients, without unduly alarming or depressing them. It must be imparted in terms within the comprehension of the average patient. The statements as to percentages of reactivation, influence of climate and altitude, etc., must conform to the authoritative consensus, and will not merely represent the personal opinion of the lecturer.] (May 15, 1943.)

[6148.] PRECAUTIONS AGAINST SPREAD OF INFECTION FROM TUBERCULOUS SECRETIONS.--(A) All tuberculous patients will be supplied individual paper sputum boxes, napkins and bags, for use on wards, corridors, etc. The patients will be instructed carefully as to the use of these articles and avoidance of expectoration and coughing other than as instructed. Used sputum boxes, napkins or gauze will be deposited



carefully in proper containers, from which they will be collected morning and evening and carried without delay to the incinerator for burning. Metal sputum cups will be collected, emptied and sterilized each morning. If patients do not strictly observe instructions regarding the use of sputum cups, napkins or gauze they will be warned and, if their carelessness continues, disciplinary measures will be taken.

(B) Food brought to tuberculosis wards will promptly be served. Leftover food from such wards will not be returned to the kitchen nor held for later service to patients, except that bread may be held over for toasting. All plates will be scraped clean of food before they are to be washed. Plate waste from tuberculous patients (as in other communicable diseases) will be kept separate from other plate waste, and will be disposed of by incineration, burial, or delivery to a public garbage disposal agency known to be not feeding such garbage to stock or disposing of it for such purpose. Such waste will not be fed to stock on the facility reservation unless after its thorough sterilization. Garbage receptacles will be sterilized with live steam for a sufficient period, and will be kept covered when in use. All dishes and eating utensils on tuberculosis wards will be kept for sufficient time in dishwashing machines to insure adequate sterilization; when washed by hand, such dishes and utensils must be thoroughly rinsed in hot water after being washed. Clean dish towels will be used for each drying process, and soiled dish towels will be promptly deposited in soiled linen containers. Particular care will be taken to maintain cleanliness of the diet kitchen, refrigerator and food carts on tuberculous wards. Nurses in charge of such wards will report promptly to the ward physician any neglect of these sanitary precautions by attendants. (May 15, 1943.)

[6149. PRECAUTIONS AGAINST HEMORRHAGE.--In infirmary, semi-infirmary and semi-ambulant wards for tuberculous patients, a hemorrhage tray, containing a package of sterile absorbent cotton, a packet of sterile gauze, an ice bag and clean towel, will be kept accessible for a nurse or hospital attendant in the event of pulmonary hemorrhage. The chief medical officer, clinical director or chief, tuberculosis service will order the drugs and other supplies that are to be kept in the medicine cabinets for use by a physician in emergencies such as pulmonary hemorrhage.] (May 15, 1943.)

6150. [CERTIFICATION OF SPUTA.--(A) Upon admission of every patient with suspected tuberculosis a series of at least 10 microscopic examinations of his sputum will be made. This series will be completed to at least 10 such examinations, even if they are all negative.

(B) Specimens will be taken from sputum cups collected by hospital attendants under supervision of the night nurse in charge of the ward. The cups will be placed in paper containers, marked with the full names and bed numbers of the patients concerned, and delivery of the cups so identified will be made to the laboratory as promptly as possible by the hospital attendant who collected the specimens.

(C) CERTIFICATION.--If any of these 10 specimens so submitted shows tubercle bacilli, the collection of a series of 5 certified specimens will immediately begin in the case of the patient concerned. These certified specimens will be expectorated in the presence of the ward physician who will thereupon identify and certify the contents upon the wrapper placed around the specimen, as follows:

This specimen of sputum was today (date), at (hour) expectorated in my presence by patient (full name), C-number\_\_\_\_; ward number\_\_\_\_, bed number\_\_\_\_.

Signature.....



(D) CUSTODY.—The specimen so certified will thereupon be immediately sent directly to the laboratory through a trusted hospital attendant, with order to deliver it into the hands of the chief, laboratory service or one of his subordinates. These specimens will never be allowed to stand about on the ward or in the laboratory unless guarded.

(E) WHEN FRAUD IS SUSPECTED.—If there is any evidence or suspicion of fraud in sputum collection, certification, delivery or examination, a new series of 5 tests will be initiated in the questionable case. A member of the medical staff will be instructed, by the clinical director or chief medical officer, to secure, personally, these additional check specimens of sputum at irregular intervals, not communicated beforehand to any other person. The specimens will be expectorated by the patient directly into a sputum cup in the presence of the said staff physician, who will at once affix the certification provided, and will promptly and personally deliver the specimen into the hands of the chief, laboratory service. (May 15, 1943.)

6151. STATUTORY DISCHARGE OF TUBERCULOUS PATIENTS.—(A) For statutory conditions attaching to discharge from a facility under section 202 (3), World War Veterans' Act, 1924, as amended, revived by section 28, Public No. 141, 73d Congress, see R. & P. R-6065. Such discharges will not be granted merely because requested by patients. All conditions entitling under the law to such discharges must be met, and the determination that they are met rests with administrative officials and is to be intelligently and conscientiously made. When it is medical judgment that further hospitalization will result in improvement, and especially when arrest of the tuberculosis is a reasonable expectation, a recognition of the responsibility for his welfare requires that an applicant for discharge in such circumstances be dissuaded in his own interests. If he still insists upon leaving the facility he will be informed that, since his condition does not meet the full requirements of the governing statute, he cannot be discharged under it, but will be discharged against medical advice. [ ]

[(B) Application for this statutory discharge will be made upon Form 2647, Request for Discharge from Hospitalization, which will be referred to a board of three physicians of the facility concerned. One of these, the chairman, will be the chief medical officer or clinical director or a designate of either. Another will be the ward physician of the patient. The third will be an appointee of the chairman. The board's findings and recommendation will be reported on Form 2647, to be forwarded to the manager. If the board disapproves discharge, the form will be filed in the patient's clinical record, and no further action will be taken. If the board recommends discharge, provided a favorable report as to the sanitary character of the patient's proposed domicile is received, the form will be sent to the manager of the regional office having jurisdiction over the territory of proposed domicile, who will arrange inspection of the domicile. The condition found will be recorded on the Form 2647, which will be returned to the facility. Upon receipt there it will be routed to the chairman of the board. If the sanitary report be unfavorable, the chairman will indorse "Application disapproved" upon the form, sign it, and send the form for filing in the patient's clinical records. The reasons for rejecting his application will be explained to the patient. If the report of the proposed domicile be satisfactory, discharge of the patient will be effectuated, and reported as "Statutory discharge, Public No. 141, 73rd Congress, section 28." Persons so discharged will thereafter be the out-patient responsibility of the regional office of jurisdiction.] (December 23, 1943.)



6152. PRECAUTIONS IN ARTIFICIAL PNEUMOTHORAX.--In the induction of pneumothorax, especially when bilateral, careful preliminary study must be made by the collapse board. In proposed bilateral procedure, the age and general condition of the patient will be considered, his vital capacity will be determined, a complete roentgenographic and fluoroscopic study be made of his chest, and a careful cardiologic examination, including an electrocardiogram, will be conducted. The opinion of each member of the board will be coordinated by the chairman, who will decide the final action to be taken. In addition, extreme care will be exercised in the induction of air into the pleural space in the absence of satisfactory manometer oscillations, and an emergency deflation bottle will be kept in the operation room and on the pneumothorax ward, ready for instant use.

In the induction of unilateral pneumothorax, the foregoing precautions will be observed, except that the determination of vital capacity and the electrocardiogram may be omitted. Sufficiently clear and full notations of the procedure will be entered in the clinical records of the patient.

Surgical collapse boards; chest surgery centers - See R. & P. 6055.  
(May 15, 1943.)



## PYSCHOTIC PATIENTS; THEIR HOSPITAL ADMISSION, DISCHARGE, TRIAL VISIT, ELOPEMENT, ETC.

6155. [POLICY IN ADMISSION AND RETENTION OF PSYCHOTIC PATIENTS.—The general policy of the Veterans Administration is the acceptance of eligible patients for hospital treatment upon application of the patients who are sufficiently competent, their guardians, relatives or representatives; and the retention of patients in hospital only when desired by them, or their guardians, relatives or representatives, or when their immediate release is contraindicated in the interest of themselves and the public. However, eligible patients who have been committed by courts of competent jurisdiction, through proceedings instituted by public officials, relatives or representatives, can be accepted for hospitalization.] (June 15, 1943.)

6156. [(A) PROPOSED ADMISSION OF A PERSON HELD ON CHARGES.—Representations of interested persons that an ex-member of the armed forces, who is being held by civil authorities on a charge of crime, was insane at the time the offense was committed, was therefore irresponsible, and should be taken over for treatment by the Veterans Administration, will not be sufficient grounds for action. Officials of the Veterans Administration will neither initiate nor participate in any action looking to admission of such offender to a facility, unless these conditions are met in full: That the question of the offender's responsibility shall have been settled by a court; that he shall have been unconditionally discharged from custody or paroled; that, if paroled, the Veterans Administration will accept no obligation for his custody if and when he is admitted to a facility, nor any obligation for the administration of punishment during his treatment therein, nor for his return to the civil authorities upon conclusion of his treatment.

(B) Hospital treatment can be authorized, provided all governing regulatory requirements are met, the treatment is needed, and a bed is available, under any of the following conditions:

1. When a defendant in a charge of crime is discharged by the court, and is free to apply for the benefit like any other potentially entitled ex-member of the armed forces.

2. When the defendant is paroled by the court, and the conditions specified in (A) are fulfilled.

3. When the court determines the defendant is insane and he is committed by a proper court to the Veterans Administration; provided there is no obligation to punish or to return the patient to the civil authorities upon release.

The fact that any such applicant is dangerous and has criminal tendencies will not in itself exclude him from hospital admission.] (June 15, 1943.)

6157 [(A) COOPERATION OF MANAGERS, CHIEF MEDICAL OFFICERS OR CLINICAL DIRECTORS WITH OTHER OFFICIALS IN DUTIES RELATED TO PSYCHOTIC PATIENTS.—A close liaison will be maintained among officials concerned, viz., managers, chief medical officers, clinical directors, social workers, finance officers, agent cashiers, adjudication agencies, and chief attorneys, in all matters entering into commitments, admissions, discharges, interfacility transfers, elopements and trial visits of psychotic patients. It is essential that the chief attorney be consulted on any question that calls for legal advice or action.



(B) Managers, chief medical officers and clinical directors will inform themselves regarding other important functions related to the care of psychotic patients which are responsibilities of associated services. The following procedures will be familiar to facility officers concerned:

Commitment of mentally incompetent beneficiaries; appointment of guardians; payment of expenses; authorization of transportation - R. & P. 5223 - 5235. Cooperation with officers in charge of institutions - R. & P. 5246. Institutional awards - R. & P. 1230-1238, 1350-1351, 4531-4537, 5260. Personal funds of patients - R. & P. 4760-4784.] (June 15, 1943.)

6158. [OBSERVANCE OF STATE STATUTES.--(A) Managers of facilities to which patients are committed under applicable State laws are usually given by such laws the same powers as superintendents of State hospitals with respect to detention, discharges, furloughs or trial visits. But in determining the advisability of and in effecting discharges or trial visits, under such existing authority, managers will comply with procedures in connection therewith, that are required by State statutes. Thus, when it is required that State officials be notified upon discharge of a psychotic patient from a facility (particularly a patient who had committed or attempted violence on other persons before his hospitalization), such notification will be provided by the manager.

(B) If a committed patient's condition justifies his discharge, the manager of the facility concerned will request the chief attorney to procure a release order from the court of commitment, except in those States where the law clothes the manager with the same authority conferred upon superintendents of State hospitals with respect to discharge or trial visit of hospitalized patients. If the manager is advised by the chief attorney that he has such authority, he may effect discharge or grant trial visit as his judgment suggests.] (June 15, 1943.)

6159. [ACTION WHEN REQUEST IS MADE FOR RELEASE OF A NONCOMMITTED PATIENT.--(A) Action when release from a facility of a psychotic patient, not held under commitment, is requested by or on behalf of the patient, will depend upon his mental condition. If he is mentally competent at the time, and can safely be released in his own interest and that of the public, his discharge will be effected; or if judged advisable, he may be permitted a trial visit.

(B) If at the time of such request for release, the patient is incompetent and his discharge would not be in his interest or that of the public, the manager will immediately communicate, in order of preference, with the guardian, if any, or the nearest relative, if any, or the representative (especially the person who may have signed Form P-10 applying for hospitalization of the patient), notifying the correspondent of the request for release, informing him of the condition of the patient and asking to be notified, in writing whether, if release is effected, the correspondent is prepared to assume charge of the patient and be responsible for his care and treatment and all expense connected therewith. If the correspondent refuses acceptance of and responsibility for the patient if discharged; or in cases where no such correspondent is located and the patient insists upon his release, the chief attorney of the territory in which the facility is located will promptly be advised of the facts, and as to the need for commitment, and he will arrange, if feasible, for local commitment proceedings. If not feasible he will without delay notify the chief attorney of the territory from which the patient was sent for hospitalization, who will arrange, if feasible, for the initiation of commitment proceedings by the guardian, if any, by relatives, or by other proper persons. If the necessary arrangements



for commitment cannot be made, the manager will notify the appropriate officials of the State, county or municipality whence the patient was sent that demand for release has been made by the patient, and that the Veterans Administration is not authorized to retain him against his desires. The aforesaid civil authorities will be requested promptly to advise when they will assume custody of the patient, and will be advised at what point the patient can be turned over to the agent of those authorities, subject to provisions of regulations, Veterans Administration, governing furnishing of transportation. The patient will be held until these arrangements are completed.

(C) If disposition of the patient as outlined in paragraph (B) is impossible, the essential facts will be reported to the medical director with specific statement as to probable danger to the patient's life or health, or danger to the public, if the manager considers that the patient should not be discharged; otherwise if the patient continues to demand his discharge he will be released.

(D) When request for release is made by or on behalf of a psychotic patient who is receiving care and treatment in a State or other civilian hospital that had been authorized by the Veterans Administration, but has not been legally committed to such hospital, the action outlined in the foregoing (A) to (C) inclusive will be taken by the manager of the regional office or facility with regional office activities having jurisdiction, in association with the chief attorney of the regional territory. (June 15, 1943.)

6160. ACTION WHEN REQUEST IS MADE FOR RELEASE OF A COMMITTED PATIENT.--A psychotic patient who had been committed by a court either within or without the State in which the facility concerned is located, will not be released upon his request or that of his agent, so long as his condition requires further hospitalization, or his discharge would be not in his own interest or that of the public. An agent, guardian, nearest relative or representative, who makes such request will be informed of the condition of the patient and advised that release will not be effected except upon a court order. (June 15, 1943.)

6161. ACTION WHEN LEGAL ACTION IS THREATENED OR TAKEN.--When legal action to force release of a hospitalized psychotic patient is threatened or begun, the manager of the facility will inform the chief attorney, who will report to the solicitor, Veterans Administration, and take such action as is in accordance with prescribed procedure. (June 15, 1943.)

6162. ACTION WHEN INTER-FACILITY TRANSFER IS REFUSED.--(A) When a patient who was not mentally disturbed when admitted to a Veterans Administration facility not adapted for the continuous care and treatment of psychoses, develops a mental condition that indicates the necessity for transfer to another and appropriate facility, his nearest relative or responsible representative will be advised of the necessity and requested to state his desire. It will be explained that the facility is not equipped to render the care necessary, and that the proposed transfer is wholly in the best interest of the patient and other hospitalized patients, and will be required unless the relatives or legal representative relieve the Veterans Administration of his care or custody. If a relative or responsible representative gives consent, the transfer will be effected in the manner provided. If he refuses, or no reply is received within a reasonable time, the transfer may be made upon the patient's consent, if sufficiently competent. If the patient is not sufficiently competent, or refuses transfer and has not been committed, the case will be referred to the chief attorney for commitment action as indicated in R. & P. 6159 (B), so that the transfer may be accomplished.



(B) (1) When transfer of a committed psychotic patient is to be made to another facility for procurement of special treatment (as for treatment of malignant tumor), such transfer will be made with or without the consent of a relative or guardian of the veteran, and without any further order of the committing court, unless the chief attorney advises that such an order is required by the State law. Care will be taken to specify "Transfer (not discharge) for special treatment; return to this station proposed." This is important when such inter-facility transfer entails removal of a patient outside the borders of the State in which he had been committed. No recommitment is contemplated in such transfers.

(2) When transfer of a sufficiently improved psychotic patient, who had been committed, is made to a facility for domiciliary care located in another State, the transferring facility will record the transfer as a "Trial visit" on Form 2557, authorizing the transfer; the Form 2593 will record the action as a transfer; and the receiving facility will enroll the transferred beneficiary in the usual manner as a domiciled member. Formal discharge of such transferred patient will be effected and recorded on Form 2593 when the maximum period allowed for trial visit has expired, and the beneficiary has sufficiently adapted to domiciliary care.

(C) Managers will not authorize or arrange transfer of a committed or an uncommitted incompetent patient from a State hospital to a facility of the Veterans Administration when the guardian, if any, or his next of kin opposes the transfer. If differences of opinion as to such transfer exist between a guardian or nearest relative or between relatives, the Veterans Administration will accept the transferred patient only if he is committed to the Veterans Administration by a court of jurisdiction, so that there may be authority to retain him if any party to the dispute demands his release. (June 15, 1943.)

6165. (A) ELOPEMENT OF PSYCHOTIC PATIENTS.--Formal discharge is appropriately given a psychotic patient when a satisfactory extra-mural adjustment is evident from report concerning him while on trial visit, or when discharge, without preliminary trial visit, is indicated because of social recovery of a hospitalized patient. It is improper to report an eloped patient as "discharged," not only because usually he will have interrupted hospitalization which had not been completed, but also because that type of discharge invites complications through State laws which require recommitment if a discharged patient is readmitted. Accordingly, the elopement of a mentally incompetent patient will be recorded on Form 2593, opposite "disposition," as "eloped;" and that status will continue until properly changed because of a subsequent disposition of the patient, as hereinafter provided. (June 15, 1943.)

(B) When an eloped patient is apprehended at a point distant from the facility from which he eloped, and the manager of a [field station in the territory of apprehension is informed of the occurrence, he will wire the medical director, who will authorize either rehospitalization in a suitable facility near the point where the eloped patient is being held, or his return to the facility from which he eloped. Rehospitalization in a suitable facility near the point where the patient was apprehended may be for indefinite continuance of treatment or only temporary residence pending later transfer to the facility of elopement. Rehospitalization will be expedited if the eloped patient is being held in jail].

(1) When hospitalization is authorized at or near the point of apprehension, the manager of the facility where the patient is hospitalized will notify the guardian, if any, or, if no guardian, the interested relative of the time and place of rehos-



pitalization; and the chief attorney in committed cases, who will notify the committing court or take such other action as may be appropriate under the applicable State law. Such rehospitalization is to be made without execution of a new Form P-10. A Form 2557, Admission Card, will record the rehospitalization. A Form 2593 will be submitted by the facility to which the patient is so readmitted. The medical director and the manager of the facility from which the patient had eloped will be notified, by the manager of the facility of readmission, when the patient is rehospitalized. When the manager of the facility from which the patient eloped is thus informed, he will have executed and distributed a completed Form 2593, showing disposition by discharge, with a notation opposite reason for disposition, reading: "Eloped (date); rehospitalized at (location, date); dropped from register of this station." That manager will also notify the chief attorney of the completed action in the case.

(2) If the medical director decides upon return of the patient to the facility from which he eloped, the manager of the territory in which the patient was apprehended will be instructed to acquaint the manager of the facility from which the patient eloped with that decision of the medical director; and the latter manager will thereupon send an attendant to bring the patient back to his station. A supplemental Form 2593 will then be submitted, with the notation: "Eloped (date); rehospitalized this station (date)." No new Form P-10 is to be prepared, no Form 2557 need be executed, and no new register number is to be assigned. (December 23, 1943.)

(C) (1) When the manager of the facility from which a psychotic patient has eloped ascertains that the patient has returned to the home of his guardian or relative, or is being held by the civil authorities at a point within or relatively near the regional territory in which the facility is located, the said manager will arrange the disposition of the patient. His action will depend upon the condition of the patient at the time. If it be decided that continuance of hospitalization is necessary, and the veteran had not been committed, the manager will so advise the guardian or relative, and state that he purposes to send an attendant to bring the patient back to the facility. If the guardian or relative agrees to this proposal, that action will be taken. If the guardian or relative objects to rehospitalization of the patient, the manager will put the guardian or relative on notice that the patient is being placed on trial visit for a period of ninety days. If the veteran was committed and further hospitalization is indicated, the manager will arrange for the veteran to be returned to the facility.

(2) If it is the manager's judgment that the patient's condition at time of elopement had sufficiently improved so that his readjustment to his community is probable, he will be placed on trial visit for ninety days. The guardian or relative will be correspondingly informed.

(3) At the end of the trial visit granted, the manager, upon the basis of reports of the progress of the patient at home, will effect the patient's discharge or recall to hospital.

(4) If the patient is being held by civil authorities, the chief attorney of the regional territory will be informed, so that he may take any necessary action.

(D) (1) If a committed patient elopes and is not apprehended or does not return to his home before the end of that period allowed under the State law as the maximum for duration of a trial visit, so that recommitment would become necessary, the status of "elopement" in which the patient is being carried will be closed out, and disposition



be made by discharge. The completed Form 2593 to be submitted in such circumstances will show discharge, with the explanatory notation, "Eloped (date); not apprehended; commitment required by State law; dropped from register this facility (date)."

(2) While a patient is being carried in elopement, his hospital bed will not be reserved, but will be cleared for use of other applicants. Corresponding entry will be made under item 3, table I, Form 2601, Monthly Report of Veterans Administration Facilities.

(E) The elopement of a psychotic patient from a State or private hospital in which he was under treatment authorized by the Veterans Administration, will be reported by the superintendent thereof to the manager of the regional office or facility with regional office having territorial jurisdiction, whereupon that manager, in association with the chief attorney, will take appropriate action in accordance with the procedure in (B) and (C) hereof. (June 15, 1943.)

6166. PENALTIES FOR INFRACTION OF HOSPITAL DISCIPLINE NOT APPLICABLE TO PSYCHOTIC PATIENTS.--Discharge from a facility or other penalties provided for infraction of hospital discipline, are not applicable to psychotic patients, except that when a psychotic patient is taken away without consent of a manager, a discharge against medical advice will be recorded, to carry the prescribed penalty. (June 15, 1943.)

6167. PASSES, [RECREATION OUTINGS,] LEAVES OF ABSENCE AND TRIAL VISITS FOR PSYCHOTIC PATIENTS.--(A) A pass may be granted a psychotic patient when his guardian, relative or friend desires to take him out on the hospital grounds, [and his condition permits. Such grounds pass will be authorized, on Form 2671, Visitor's Permit, by the information clerk (see R. & P. 6112), who will checkmark "on grounds," subject to prior standing instructions given by the ward physician. Those instructions to the information clerk will be countermanded upon such change in the patient's condition as interdicts grounds privilege.]

(B) [(1) Recreation outings of less than 24 hours duration may be authorized, by managers for patients who have sufficient funds to their credit in personal funds of patients to defray the expense of the outing, in excess of funds to meet anticipated needs for personal clothing and comfort articles and services. Recreation outings will be so authorized only when it is medical judgment that patients can safely be taken upon them and will derive therapeutic benefit from them. They may involve expense for transportation (such as a common carrier or private automobile), incidental meals, tickets to ball games, etc., for the patient and the attendant, plus the attendant's fee; or they may involve no expense other than the attendant's fee, as in walks about the vicinity of the hospital grounds. The manager is hereby empowered to designate an employee who is a physician, or as many as may be required in his judgment, to approve these outings.

(2) Provided the controlling conditions of (1) are met, managers or their designates may authorize outings for a patient who has no guardian or relative. For a patient with a guardian, outings will not be authorized until the written consent of the guardian is obtained. In requesting that consent, the guardian will be informed regarding the nature of the proposed outings, their total number, their frequency, and the approximate amount they are to cost. For a patient with no guardian but with a friend, a similar procedure will be followed as in the instance where there is a guardian.

(3) A hospital attendant at the facility concerned may be permitted to take a patient upon recreation outings, provided that such accompaniment will not interfere



with the performance of the regular duties of the attendant. For each hour of such service, the manager may authorize no more than the amount of the hourly rate of salary that is being paid him as an employee of the Veterans Administration; and for any one outing, regardless of the hours consumed in it, his fee will not exceed the amount of his Government salary for one day. If an automobile be hired for the outing, payment for its use will be on a mileage basis, not to exceed four cents a mile. If more than one patient is sent on an outing with one attendant, the latter's fee may be increased twenty-five percent for each such additional patient; but no added allowance will be granted for use of an automobile and the total for the expenses will be prorated equally between the patients taken on the one outing.

(4) Where an outing is to be furnished and payment is to be made from the funds to the credit of the patient, the ward physician will cause to be prepared the appropriate request in duplicate, which will give the name of the patient and attendant to be employed, the nature of the outing, items of expenses to be incurred, approximate cost of each item and total cost of all items, the names of other patients going on the outing, and a statement whether consent of the guardian has been obtained and whether advance of funds will be necessary. The original request will then be forwarded to the finance officer for determination as to available funds. If funds are available, the finance officer will so indicate on the request and forward it to the manager or his designate for approval. If advance of funds is not necessary, the approved request will be returned to the ward physician, who will deliver it to the attendant. Upon completion of the trip, the attendant will return the request to the ward physician with an itemized statement of expenses incurred, giving the places visited and speedometer readings on departure and return, if a private car was used. The ward physician will consult with the patient and satisfy himself that the bill is correct. He will then cause a voucher to be prepared in the name of the attendant, which will then be submitted for payment the same as any other voucher. In the event an advance of funds is necessary, the request will be returned by the manager or his designate to the finance officer for preparation of a cash voucher payable to the manager or his designate; but upon completion of the outing the funds will be accounted for the same as when no advance has been made. If the amount advanced exceeds the amount expended, refund will be made. If the amount expended exceeds the amount advanced, an additional cash voucher payable to the manager will be prepared to cover the excess sum expended.

(5) If a patient has insufficient funds to his credit to provide necessary or desirable recreational outings, the manager or his designate may suggest to a guardian or near relative or close friend the advisability of furnishing funds to provide recreational outings and may request funds for this purpose but under no circumstances may the manager or his designate or any other employee demand of a guardian, near relative or close friend, funds for this purpose. In the event a guardian refuses to meet his obligation in this respect, the manager or his designate may call the matter to the attention of the chief attorney who has jurisdiction of the case.

(6) Nothing herein provided will prevent a guardian or relative making private arrangements to provide recreational outings for his ward. However, when a guardian or relative makes private arrangements with an employee, the manager will be advised of the arrangements, but payments to the person employed will be made by the guardian or relative. Employees are forbidden to solicit such employment by guardians or relatives.

(Paragraph 6167 continued.)

(7) Recreational outings are not to lessen recreation provided by the Veterans Administration. The expenditure for an outing is not limited to \$5.00; however managers will guard against extravagance and the exploitation of patients.】

【(C)】 Leave of absence, as a therapeutic measure tending to stimulate extra-mural adjustment, may be granted psychotic patients 【whose condition permits】. The guardian or relative who comes to the hospital to take a patient upon leave of absence will be required to execute Form 2832 aforesaid, upon which will be specified the time limit upon the leave. The chief medical officer or clinical director will 【approve (or disapprove a ward physician's recommendation for a grant of leave. The escort will clearly be informed of the date when the patient is to be returned to the hospital.】

【(D)】 (1) Trial visits are to be encouraged, not only because they are in the interest of the patients, but for clearance of available beds to accommodate other psychotic applicants. Managers, chief medical officers and clinical directors will at all times have this administrative objective in view. Requests for grant of trial visits from relatives of patients will have liberal consideration, but will not be awaited; the initiative should be taken by the station, as a planned part of treatment.

(2) Before a patient is sent on trial visit, preliminaries must be disposed of. It will be developed, through a social worker, whether there is any domestic or financial situation in the home of the patient which would make the trial visit inadvisable for him or his family; and, if so, whether it can be adjusted. The consent of the guardian, relative or other responsible representative, to the proposed trial visit will next be procured, through execution of Form 2832, Responsibility for Custody of Patient, 【     】 which will be filed in the facility correspondence file relating to the patient. The manager will provide the necessary funds to the patient or the person into whose custody the patient is released, as provided by R. & P. R-1278 (A). See also R. & P. 1350 and 1351: (December 23, 1943.)

(3) A trial visit may initially be granted for from thirty to ninety days, as indicated in the case, subject to extensions up to that maximum period (one year in certain States) beyond which recommitment would be required under the State law. But extensions beyond six months should be exceptional, since within that period



it can ordinarily be determined from reports whether extra-mural adjustment is probable and, accordingly, whether the patient should be discharged from the facility, or his custodian be advised to return him.

(4) The person who is to accept the patient will be instructed, should the patient relapse so that he cannot be kept at home, to return him to the facility; and that transportation and other expenses incident thereto cannot be supplied at Government expense to cover travel from or to a facility in connection with a trial visit, except when the patient has no funds to his credit at the facility, and the custodian alleges inability to defray such expense and executes affidavit accordingly (see R. & P. 6079 (A)). However, if subsequently it is determined that the patient had funds to his credit with a guardian or elsewhere, the cost of the travel at Government expense will be recovered from those funds. The person who has accepted responsibility for the patient will further be instructed to report, at the end of each month of the prescribed period of trial visit, the condition of the patient, and the custodian's desire to continue the responsibility.

(5) When a patient proceeds on trial visit, the facility will submit a supplemental Form 2593, Record of Hospitalization or Domiciliary Care, showing the period of trial visit granted. The patient's bed will be considered vacant but, until he is discharged, he will be carried on the hospital roll, though not recorded in periodic administrative reports of the patient population. When a patient is returned from a trial visit, a supplemental Form 2593 will be submitted, marked "Returned from trial visit," with date thereof. This form will bear the same hospital register number and admission date as the Form 2593 that was submitted when the patient proceeded on the trial visit.] (June 15, 1943.)

[6168 & 6169 canceled June 15, 1943.]

#### PSYCHOTIC PATIENTS: THEIR MENTAL INCOMPETENCY

##### 6170. [DETERMINATIONS FOR RATING AGENCIES AND FOR OTHER ADMINISTRATIVE PURPOSES.--

(A) For determinations of sanity and mental competency or of insanity and mental incompetency to be made by neuropsychiatrists for consideration of rating agencies in awarding monetary benefits, see R. & P. R-1173-1174. The finding by two neuropsychiatrists will be required as the basis for such ratings; except that when the services of two cannot be conveniently or economically obtained, the opinion of one neuropsychiatrist will be accepted as sufficient.

(B) See R. & P. 4761 (A) (3), with respect to the safeguarding and handling of funds of patients. See R. & P. 4776 (A) as to evidence establishing mental competency to accompany voucher prepared in favor of a patient discharged as competent, with no guardian; and R. & P. 4776 (B) for certificate of manager as to ability of a beneficiary, about to be discharged, to receive and handle funds to his credit, when such patient has no guardian.] (June 15, 1943.)

[6171. DEFINITION OF INSANITY.--For general purposes an insane person or lunatic may be defined as one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basic condition, exhibits, due to disease, a more or less prolonged deviation from the normal method of behavior, and who is thereby rendered incapable of managing his own affairs or transacting business with ordinary prudence; or who is dangerous to himself, to others, or to property; or who interferes with the peace of society; or who has so departed (become anti-social) from the accepted standards of the community to which by birth and education he belongs, as to lack the adaptability to make further adjustment to the social customs of the community in which he resides.] (June 15, 1943.)



[6172. CONSIDERATIONS IN DETERMINING MENTAL INCOMPETENCY.--In the rating of neuropsychiatric cases where the competency of a claimant is an issue, it should be borne in mind that the incompetency of an individual is purely a question of fact, to be proven by affirmative evidence in rebuttal of the prima facie presumption of competency. A distinction is recognized between a psychosis as a mental disease and incompetency as an existing fact. The one is not necessarily dependent on the other. This principle is not always given the attention it should have; a rating of incompetency is apt, usually, to follow a determination that the person is psychotic; and sometimes incompetency is set down in a rating which is for less than totality of disability from psychosis. Neuropsychiatric examiners and medical specialists on rating or appellate boards must have in mind always considerations of pressing practical importance as apart from the purely medical considerations relative to incompetency. They must understand the consequences - the expense and inconvenience entailed upon beneficiaries - when a determination of incompetency is made. An existing mental disease is not in and of itself always sufficient to warrant the invoking of a judicial process, with the consequences mentioned which are inevitably incident to a legal adjudication of incompetency. The finding of incompetency should be based upon the answer to these questions: Is the individual capable of managing his affairs without gross dissipation of his funds due to utter lack of appreciation of value or complete disregard for his own actual needs and those of his dependents? This question can be answered by interrogation of the individual whose competency is in question, or relatives or friends, by the examining neuropsychiatrist. Where mental examination of the veteran or interrogation of his relatives leaves the neuropsychiatric examiner still in doubt on the point at issue, the report of a social worker, showing pertinent facts as to the past history and recent acts of the veteran, especially as concerns his ability to manage his affairs, may be obtained, to assist in the determination. Intelligently liberal practical judgment as to the relative capability of a beneficiary to manage his affairs without gross dissipation of his funds due to utter lack of appreciation of values or complete disregard for his own actual needs and those of his dependents is especially called for where relatively small monthly awards with no large retroactive payments are to be made.] (June 15, 1943.)

[6173. EFFECT OF DETERMINATION WITH REGARD TO APPOINTMENT OF A GUARDIAN OR REDUCTION OF MONETARY AWARD.--(A) If in any case the medical reports show the existence of a psychotic condition leaving no doubt as to the question of the veteran's incompetency - within the above definition - rating may be made accordingly. In any other case, and particularly those wherein the monthly payments are small, the rating agency before rating as to incompetency will refer the case to the chief attorney for development of sufficient industrial and social evidence to afford proper basis for determination of claimant's ability to receive and handle the amount payable. The rating agency may request the opinion of the neuropsychiatric examiner upon the evidence submitted by the chief attorney, but the rating will be made upon all the evidence, including the examiner's report and that of the chief attorney. Subject to right of appeal, such rating of incompetency so made shall be final, and shall furnish the basis for appointment of a guardian for the claimant.

(B) A rating of incompetency or insanity made in accord with the foregoing, or on a report of mental examination from an institution in which the veteran is being furnished hospital treatment, institutional or domiciliary care by the United States



or any political subdivision thereof, will be sufficient basis for reduction or discontinuance of compensation, pension or emergency officers' retirement pay, under the governing regulation, when the other conditions thereof are met.] (June 15, 1943.)

[6174. MENTAL INCOMPETENCY AS RELATED TO INTERFACILITY TRANSFER.—(A) Transfer of a psychotic patient from hospital treatment to domiciliary care will be governed by the provisions of R. & P. 6051 (B) and the specifications of fitness for domiciliary care outlined under "Directions" on Form 2649, Request for Interfacility Transfer. The patient's condition at the time of the proposed transfer must be such as, in medical judgment, will in all probability permit of his being adjusted to the requirements of domiciliary care. It is not practicable nor expected that such transferred patients shall receive that character of supervision and service which is provided them during hospital treatment. Except as to funds only, of those beneficiaries for whom a fiduciary has been appointed, which funds must therefore be continued to be handled through the fiduciary or with his consent by the manager, or by the manager through an institutional award, all patients, when transferred to domiciliary care, will receive in every respect the same care given other members in barracks. If such beneficiaries relapse during domiciliary care, so that they cannot meet the requirements for such care, they will revert to a hospital status, and will then be transferred from barracks to hospital of the same facility or, as necessary, be transferred back to the facility from which they had been sent for domiciliary care.

(B) The instructions on Form 2649, Request for Interfacility Transfer, require that a medical and industrial history of the beneficiary be forwarded to the receiving domiciliary facility. This is necessary to inform such facility as to the historical background of the case. If, in such history, an unqualified statement is made that the patient being transferred is "Incompetent and insane," the receiving facility, not understanding that this characterization is not clinical, but is of purely legal or perhaps administrative significance, may conclude that the patient is not fitted for domiciliary care. To prevent such difficulties, due explanation will be made by the transferring facility, viz., that while the patient had been legally declared incompetent or insane, or during hospitalization had administratively been so designated for hospital purposes, he is, at the time of proposed transfer, capable of meeting the requirements for domiciliary care, by reason of remission or recovery. It should also be stated that he is free from any associated physical disorder which would unfit him for domiciliation. It will be evident that unless he is in that improved or fully recovered condition he cannot properly be considered for such domiciliary care in view of the conditions that will surround such care, as set forth in (A) hereof. The medical and industrial history so prepared will be enclosed with the Form 2649 sent to the director of national homes, so that he may have sufficient basis for his approval or disapproval of the request for transfer. He will enclose that history with the Forms 2649 he returns to the facility requesting the transfer; and, if he approves the transfer, the transferring facility will forward that history with the copy of the approved Form 2649 that is sent to the receiving domiciliary facility.] (June 15, 1943.)

#### PSYCHOTIC PATIENTS: THEIR TREATMENT AND CARE

6175. [MANAGERS TO CLAIM ACCRUED PAY DUE INCOMPETENT EX-SOLDIER PATIENTS.—(A) When, in accordance with a mutual agreement, a commanding officer of an Army



hospital delivers, at a facility designated by the medical director, a psychotic soldier, for discharge at and treatment in that facility, the manager thereof will be supplied a check from the Army hospital in the amount of such funds as the patient then had on deposit to his credit at the Army hospital. But that amount does not represent the patient's final pay and allowances, for which a claim must be made upon the General Accounting Office, Washington, D. C. (For procedure in filing claims - see R. & P. 4760-4762.)] (June 15, 1943.)

[6176 canceled June 15, 1943.]

6177. [SPECIAL RESPONSIBILITIES OF PERSONNEL IN FACILITIES FOR PSYCHOTIC PATIENTS.--The responsibilities of employees engaged in the treatment and care of psychotic patients are especially important and confidential. Unauthorized information concerning patients, the facility or its employees, given to persons not connected with the facility, will be considered sufficient grounds for preferment of charges. Ward physicians and officers of the day will instruct nurses and attendants as to the maintenance, at all times, of close observation of patients known or suspected to have suicidal, homicidal, pyromaniacal or elopement tendencies, and will assure themselves of a full understanding and compliance with such instructions. The night supervising nurse will visit each ward as often as is necessary during her rounds, and note particularly the supervision being given such patients. Nurses will make reports on all such patients and others who are unduly restless or troublesome, or under restraint or seclusion, or requiring special treatment. Any apparent suicidal attempt of a patient will be promptly reported to the ward physician, or, in his absence, to the officer of the day. Many neuropsychiatric patients entering a hospital are apprehensive and suspicious. Everything possible will be done to allay such fears, and all employees will be careful both in manner and language with these patients. No employee will assist a patient in any clandestine correspondence or fail to report any knowledge thereof. Attendants will be required to familiarize themselves thoroughly with "Instructions for Hospital Attendants in Veterans Administration Facilities," with particular regard to duties in connection with psychotic patients, as detailed therein.] (June 15, 1943.)

6178. [PRECAUTIONS UPON ADMISSION OF PSYCHOTIC PATIENTS.--(A) Upon admission to the reception service, all neuropsychiatric patients will be examined for evidence of wounds, bruises or other injuries. Note of these findings, whether negative or not, will be made on the clinical record of the patient. The chief, reception service, will also, at the time of admission of a patient, make a brief but accurate note of the physical description of the patient (including height, weight, color of hair and eyes, loss of body parts, scars, tattoo designs, or other identification aids), to be furnished in the event of elopement of the patient.

(B) The chief, reception service or, in his absence, the officer of the day will tactfully question the patient being admitted (if sufficiently competent) to develop suicidal ideas. There will also be ascertained from the attendant accompanying the patient, from any written data submitted, or from statements in the court papers, if the patient was committed - whether there is a history of suicidal tendency.

(C) If the history is significant or the patient's conduct or talk suggests a suicidal tendency, he will at once be placed in a ward set apart for such patients, designated as an "observation" ward. While the characterization "suicidal" will not be applied to this ward nor to these patients, it must always be understood that these patients must be kept under observation to prevent attempts at self-injury, and any personnel who are newly assigned to duty on such ward must be instructed accordingly.



(D) Patients known or suspected to have suicidal tendency will be assigned to dormitory beds in a group nearest the attendant's station on the ward, and such patients will be kept under his constant supervision. Such attendant will never leave his station until he is relieved by another. The clothing and bedding of such patients will be searched each night and morning, to prevent the secreting of dangerous articles. They will be accompanied to the toilet room by an attendant. All toilet rooms, and utility or private rooms opening off the ward will be kept locked day and night.

(E) If the physical condition of any such suicidal patient will not permit of his being cared for with the group of like patients in the day room, he will be kept under supervision of an attendant at all times, and by a special attendant if determined necessary.

(F) The physician in charge of such observation ward may transfer any such patient from one bed to another on the same ward. But no such patient will be transferred from the observation ward to another, until such action is approved by a two-thirds majority vote of the members of a clinical conference of the staff, provided that that majority must include the chief medical officer or clinical director (or chief of neurologic service) and the physician in charge of such observation ward. When a patient is so transferred from such observation ward, the physician in charge of the ward to which the transfer is made will instruct the personnel under him to continue special attention to such transferred patient until he is reasonably confident that precautions can safely be relaxed.

(G) The foregoing procedure will be carefully observed not only as to newly admitted patients, but also as to patients who having been hospitalized for a greater or lesser period, develop suicidal tendency requiring transfer to a ward adapted for their special care.

(H) The "observation" ward should have decorations and furnishings that are as attractive and cheerful as possible. The personnel on that ward must be particularly dependable, and definite, continued effort must be made to awake the interest of these patients and to keep them occupied. Every opportunity will be afforded them to engage in occupational therapy, group therapy and recreational activities. Patients who are actively suicidal may have such activities brought to them on the ward, care being taken that no sharp instruments or potentially dangerous equipment be used. Patients who are less suicidal can be taken to regular daytime entertainments or to classes, in groups, with special supervision.】 (June 15, 1943.)

6179. 【FORCED FEEDING OF PSYCHOTIC PATIENTS.—When forced alimentation of psychotic patients is required, ward physicians will personally conduct the tube feeding. In no circumstances will a nurse or attendant be ordered or permitted to tube-feed patients.】 (June 15, 1943.)

6180 【PSYCHOTIC PATIENTS NOT TO BE ALONE ON WARDS.—No psychotic patient will be permitted to remain in a ward without the presence of a nurse or other employee.】 (June 15, 1943.)

6181. 【OUTDOOR EXERCISE FOR PSYCHOTIC PATIENTS.—Unless otherwise ordered by ward physicians, nurses in charge of wards will get all psychotic patients out for exercise in suitable weather, accompanied by attendants. Patients taking outdoor exercise will be kept in column and not allowed to scatter, loiter, or get out of sight behind shrubbery, buildings, etc. One attendant will station himself at the head of the column, another at its rear, and one on each flank. Patients inclined to suicide,



elopement or belligerency will be placed at the rear of the column, under direct and continuous observation. Patients on outdoor exercise will be neatly and suitably clothed for the weather.] (June 15, 1943.)

6182. [COUNT OF PSYCHOTIC PATIENTS.--Patients taken out for exercise, assigned to occupational therapy, or proceeding to meals or entertainments will be counted upon leaving and returning to the wards. These counts, which will be made by the ranking attendant, who will check with other attendants of the party, need not be recorded. A patient count will also be made at the shifts of personnel, 11 p.m. and 7 a.m., and at such other times as ordered. The count upon relief from duty at 11 p.m. and 7 a.m. will be made jointly by the charge attendant going off duty and the one coming on. A personal check of the actual presence in the ward of each patient will be made by them. The names of the patients, as they are identified and accounted for, will be checked off on Form 2831, Daily Check of Patients by Wards. That form, certified by the initials of the charge attendants, will be delivered to the charge nurse coming on duty at the shift, who will affix her certification by initialing the form, if she feels assured that the count was faithfully made. If she is in any doubt, she will require a recount. Forms 2831, so certified, will be placed in a manila folder, held for thirty days, then destroyed. If any count shows a patient missing, his ward physician will at once be notified, and he will direct an immediate search of buildings and grounds. If local search is not successful, the manager, chief medical officer or clinical director will order the further action to be taken. See R. & P. 6165 for procedure in elopement of psychotic patients.] (June 15, 1943.)

6183. [FREEDOM OF GROUNDS FOR PSYCHOTIC PATIENTS.--(A) The grant to selected patients of the privilege of unattended access to the hospital reservation is to be regarded as mental therapy, prescribed to foster progressive rehabilitation.

(B) Patients exhibiting interest and initiative in occupational therapy assignments and recreational activities, and who are not suspected of suicidal or homicidal tendencies, are those who should be especially considered for grant of this privilege.

(C) When, in the opinion of the clinical director or ward physician, a patient is suitable for grounds privilege, his case will be presented at a staff conference, where a majority vote will decide whether the privilege will be approved or disapproved, and if approved, whether it will be limited or full. A notation of the conference action will be made by the ward physician on Form 2614j of the patient's clinical record.

(D) A grant of privilege of the grounds may be (1) limited and (2) full.

(1) A limited grant will specify freedom of access to designated parts of the reservation for designated periods of the daytime only, but with the further privilege of going unattended to occupational therapy assignments. Patients granted limited grounds privilege will be required to be on their wards at dusk, and their visits to the library or to other recreational activities after nightfall must be made in the company of attendants.

(2) A grant of full grounds privilege will not include restriction to designated parts of the reservation; and need not, unless determined proper, carry any restrictions as to daytime hours governing its use. But patients granted this full privilege will be required to be back on their ward at dusk. However, they may, with permission of the ward physician attend, unaccompanied, recreational activities, including the library, after nightfall. (3) All patients granted either limited or full grounds privilege must be on their wards at bedtime.

(E) Patients granted limited grounds privilege can be further granted a full grounds privilege only after a majority vote of a staff conference. If the condition of a patient granted grounds privilege so changes as to raise a question as to the safety of the grant, the case will be presented, by his ward physician or the clinical director, to a staff conference. A majority vote at such conference will decide



whether the privilege, if limited, shall be continued or revoked; and, if full, shall be continued, revoked, or reduced to a limited privilege. The nurses and attendants of the patients' ward will promptly be put on notice by the ward physician of any revocation or reduction of his grounds privilege, and the ward physician will record the staff conference action upon Form 2614j of the patient's clinical record.

(F) Patients granted grounds privilege will be supplied with Form 2607, Privilege Card. On the back of that card, if the privilege be limited, will be stated the parts of the grounds to which the patient is permitted access. On the face of the card the daytime hours will be entered for all patients granted limited grounds privilege, and for those granted a full privilege if it is decided their freedom of the grounds should be restricted to certain hours. The patients supplied Form 2607 will be clearly informed as to the nature of the privilege authorized them. If the facility is adjacent to a military reservation, these patients will be cautioned against trespassing upon or even approaching that reservation.] (June 15, 1943.)

6184. [OCCUPATION OF PSYCHOTIC PATIENTS.--(A) Psychotic patients whenever possible, will be prescribed some form of occupational therapy or will be kept engaged in group therapy activities. Patients too mentally deteriorated or too physically infirm for such activities will be provided habit-training in occupational therapy.

(B) (1) The activities of the units in the group therapy organization, occupational therapy, bibliotherapy, social recreation and, sometimes, physical recreation, are to be coordinated to devise a concerted program with daily scheduled hours for each unit. The heads of these units will function as a committee, with the reconstruction officer as chairman, to arrange and continuously conduct the program. While patients engaged in group therapy activities will be directed mainly by attendants, all personnel of the facility will be expected to cooperate, as required.

(2) Primarily, group therapy activities should reach the patients for whom occupational therapy has not been prescribed, whether on Form 2614-l or 2614j. Secondly, group therapy will make provision also for a number of patients who are receiving occupational therapy. This will occur in connection with the moving picture program, physical exercise, and certain other recreational activities.

(C) (1) Habit-training in occupational therapy will be organized (in a space separate from the ward area) into three classes, based upon behavior conditions, as follows:

a. The class of mentally deteriorated patients

b. " " " " less regressed " " "

c. " " " " semi-infirm " " "

(2) Habit-training of kindergarten type will be given the (a) class, mentally deteriorated patients, by female aides who have had training in this work.

(3) Classes (b) and (c) will be composed of patients of a higher behavior type, who for some reason cannot be assigned to the industrial projects of occupational therapy; and patients who, because of physical infirmity, are similarly excluded from the industrial projects. Arts and crafts will be provided for these two classes in the habit-training group, and further assignment to arts and crafts projects in the regular occupational therapy program should be prescribed for them, if possible.

(4) Promotions should be made from time to time as the behavior of the patient improves, with a view to effecting assignment to the industrial groups of occupational therapy as soon as improvement warrants. A 24-hour program in habit-



training should be organized for this group, and a distinction made between the habit-training activities of a personal nature and the habit-training and kindergarten type of occupational therapy supervised and directed by trained personnel appointed for this purpose, although there must be close coordination between these.] (June 15, 1943.)

6185. [PERSONAL SERVICES OF PSYCHOTIC PATIENTS; THEIR ACCESS TO PERSONAL QUARTERS.—(A) No psychotic patient will be allowed to render personal service for any employee of a facility, either as occupational therapy or as wage or job work, and this prohibition will extend to services for concessionnaires, delivery of newspapers or magazines to personnel or patients, etc.

(B) Patients will not be allowed to enter quarters of personnel except for official reasons, and then only when accompanied by an attendant.] (June 15, 1943.)

6186. [ENTERTAINMENT OF PSYCHOTIC PATIENTS.—See Recreational Activities. In baseball games, the bats, which will be restricted in number, will remain in the custody of an attendant, who will issue to the batter any one bat he may select. In attending entertainments or religious services, etc., patients will be accompanied by attendants, who will exercise proper supervision over them. See Patient Count.] (June 15, 1943.)

6187. [VISITORS TO PSYCHOTIC PATIENTS.—(A) When psychotic patients have visitors, ward nurses will be informed of their coming by the clerk who is assigned to issuing visit permits, before they are allowed to go to the wards, so that the patients may be clothed properly to receive them. Where visitors are not allowed to enter the wards, but the psychotic patients are brought to a reception room to meet visitors, attendants will observe the patient from time to time during the visit, and assure themselves that the patients are not being supplied with any articles which are forbidden to be in the possession of psychotic patients.

(B) Control of visits.—Managers, chief medical officers and clinical directors will have in mind proper restrictions upon visits to wards of psychotic patients, to prevent upsetting influences on patients and to discourage unhealthy curiosity on the part of visitors. Disturbed patients will be visited only by guardians or relatives, and the time of such visits is to be limited, or the visits to be wholly prohibited, if in medical judgment necessary. Visits to non-disturbed patients will be permitted guardians, relatives, persons sufficiently identified as close friends, and members of recognized ex-service men's organizations, when visiting stations in connection with activities of the organization which they represent. Of any one party of visitors no more than three of its members will be allowed to visit a ward. Corresponding instructions will be given the visit permit clerk of the facility. The provisions of this subparagraph also apply to employees of the Veterans Administration, whose official duties do not require their access to any and all patients in a facility.

(C) Visit Record; Visitor's Permit - (1) Form 2820, Visit Record, will be used in recording visits of relatives, guardians, conservators or committees to psychotic patients. The main purpose of this form is the maintenance of the record of such visits for use in auditing reports and accounts looking to reimbursement of guardians conservators, etc., for travel in connection with their wards. These forms will be executed by the clerk at the information desk, from data on the Form 2671, Visitor's Permit, and will be forwarded to the chief attorney (see R. & P. 6112 (D)), in accordance with his instructions.

(2) Permits to visit psychotic patients will be issued as provided in R. & P. 6112 (D).] (June 15, 1943.)



6188. [VISITORS TO GROUNDS.--Persons visiting the grounds of a facility for psychotic patients will not be allowed to loiter about the buildings or talk to the patients. Employees noticing that patients are attracting the attention of visitors about the grounds will report the occurrence to a guard.] (June 15, 1943.)

6189. [PRECAUTIONS IN FEEDING PSYCHOTIC PATIENTS.--Attendants will be required to remain constantly in the dining room during meals of psychotic patients. When it is necessary to feed such patients outside of dining rooms, knives and forks will not be given them if they are known or suspected to have suicidal or homicidal tendencies. The greatest care will be exercised that knives or other articles are not taken from the dining room by patients: Knives, forks and spoons will be collected by attendants and counted after each meal, before the patients leave the tables. Should any such article be missed, all patients will be searched before they are allowed to leave the dining room.] (June 15, 1943.)

6190. [PRECAUTIONS AGAINST FIRE.--(A) See R. & P. 3920-3922, as to posting of fire regulations and fire drills, and R. & P. 3924 as to smoking in pharmacies, laboratories and other hazardous sections. Every precaution must be taken to prevent possession of matches or other inflammable articles of any kind by psychotic patients. Attendants will supply lights for cigarettes, etc.

(B) In case of fire, the nurse in charge of the ward in or near which the fire occurs will immediately report it in accordance with the fire regulations of the facility, and will quickly assemble her patients in the corridor outside of the ward, and then close the doors of the ward. A rapid patient count will be made immediately the ward is evacuated, for assurance that no one was left in the ward or rooms opening upon it.] (June 15, 1943.)

[6191. BATHING OF PSYCHOTIC PATIENTS.--(A) Psychotic patients must always bathe in the presence and under immediate supervision of an attendant, and the bathroom must never be left for an instant by the attendant until all the patients have completed their baths and have been conducted from the bathroom. Patients will never be permitted to enter the bath tub or shower until the water has been tested by the hand of the attendant as to temperature. The proper bathing temperature of the water must never be adjusted while the patient is in the tub or under the shower. If at any time the temperature of the water or bathroom is not suitable, bathing will be discontinued and the fact reported to the chief medical officer or clinical director. Patients who are infirm or have a partial motor or sensory paralysis will be assisted in bathing by an attendant assigned solely to such patients. Ward physicians will instruct such attendants carefully as to the temperature of water to be used and care to be exercised in bathing such patients. Disturbed or hyperactive or physically incapacitated patients will be individually bathed, no other patient or patients being placed under the shower with them.

(B) A physician will be present at the beginning and ending of a continuous tub bath. The pulse and respiratory rate of patients in continuous flow tubs will be taken every thirty minutes, if they are not too disturbed to make this possible. The temperature of the water in the tub will also be ascertained at the same intervals.] (June 15, 1943.)

[6192. BARBERING OF PSYCHOTIC PATIENTS.--(A) Regardless of their financial status, neuropsychiatric patients will be supplied barbering service (haircutting and shaving). Such of them as are determined to be mentally competent may be allowed to



shave themselves with safety razors, but always under immediate supervision of attendants, and safety razors or blades will not be issued to nor allowed in possession of such mentally competent patients, except at time of shaving.

(B) The shaving of mentally incompetent patients will be done, with safety razors, by hospital attendants; or by facility barbers, with safety razors or with open razors, if the latter type of razor is permitted by the manager. Such permission can be given only upon the condition that open razors when not in use will be under lock in possession of the barber, and that when in use they will never leave the barber's hands.

(C) Haircutting of these patients will be done by facility barbers (contract or otherwise), or by hospital attendants. The hair of male patients will be cut once monthly or oftener for a good appearance. The hair of female patients will be cut only upon permission of their ward physicians.] (June 15, 1943.)

[6193. USE OF PACKS.—Dry packs will not be used. Wet packs may be used only when prescribed by the patient's ward physician; or by the officer of the day in the absence of the ward physician; or by the chief medical officer or clinical director. The prescription for such pack will be recorded on the clinical record, Form 2614m, of the patient. A physician will be present when a patient is placed in a wet pack; at the conclusion of the pack; at least once during (midway of) the pack, and oftener if judged necessary; and at any other time he may be summoned to observe the patient in the pack. If he is not too disturbed to make it impossible, the pulse rate of the patient will be taken in his radial artery before he is placed in the pack, and his respiratory rate will be counted. At thirty-minute intervals while he is in the pack, his pulse (at the temporal artery) and respirations will be counted. The pulse count can be omitted if the patient goes to sleep in the pack.] (June 15, 1943.)

[6194. RESTRAINT AND SECLUSION OF PSYCHOTIC PATIENTS.—(A) Policy in — The use of any form of mechanical restraint of psychotic patients will be reduced to the minimum of absolute necessity, and the chief medical officer or clinical director will be responsible for close personal supervision of the use of these measures. For disturbed patient, reliance will be placed instead, so far as possible, upon hydrotherapy.

(B) Ordering of; Conditions Governing — Mechanical restraint or seclusion will be employed only upon the order of the patient's ward physician, who will be present at and will supervise the first application of either measure. The order, which will be entered as a prescription on the clinical records of the patient, Form 2614j, will be good for twenty-four hours only, and must be re-executed in the same written form for each subsequent day of required restraint or seclusion. The maximum period through the day during which restraint is to be continuously employed will be three hours, at the end of which period it will be removed, to be reapplied after an appropriate interval, if so ordered by the ward physician. The maximum period of continuous seclusion will not exceed four hours, when it will be interrupted, to be resumed if indicated in the judgment of the ward physician. A patient in seclusion will be observed carefully every half-hour.

(C) Report of — From the orders of ward physicians, a monthly report of restraint and seclusion will be made up on Form 2683, and will be filed at the facility, in a manila folder, in the clinical clerk's office, for review by the chief medical officer or clinical director, and for inspection by supervisors of the medical and hospital service. These reports will be reported at the end of one year for disposition as inactive records.



[6195. RESPONSIBILITY IN ELOPEMENT OF PSYCHOTIC PATIENTS.—The elopement of a psychotic patient without the knowledge of the nurse or attendant in charge of him, or when such escape is not promptly reported to the manager when discovered, will be investigated by the manager and appropriate action taken.] (June 15, 1943.)

[6196 and 6197 canceled June 15, 1943.]

### EPILEPTIC PATIENT

6198. [(A) Care of - The imminent probability of injury that may be sustained by an epileptic beneficiary during a paroxysm must always be borne in mind, and ward surgeons will carefully instruct nurses and attendants having care of such patients as to measures to be taken to safeguard against such injuries, including the handling of an epileptic during an attack. To prevent injuries following falls from a bed during nocturnal seizures, low beds will be provided epileptic beneficiaries. A sufficient amount of the legs of regular hospital beds will be cut off to bring the top of the spring 18 inches from the floor. The leg pieces cut off will be fitted on the inside with firm metal rods or segments of pipe size to fit snugly and riveted to the cut-off leg pieces. The metal rod or piping will extend so that it can be fitted into the leg of the low bed. A set screw may be placed in the upper section, if desired. This mechanical arrangement will make a bed adaptable either for a low size or for a standard size, as required. To secure the desirable uniformity in height of beds on wards, epileptic beneficiaries should be placed, whenever possible, in single or double rooms or in small wards. Applicants for domiciliary care who have a history of epileptic attacks, when admitted through the reception service, will be retained in that service or in special rooms or small wards, as above referred to, for a period of observation to determine whether they shall be retained in hospital or can be transferred for domiciliary care. All epileptic beneficiaries receiving domiciliary care who, in the opinion of the chief medical officer, require hospital treatment, will be transferred for hospital observation and treatment, with return to domiciliary status if sufficient improvement be secured through hospitalization. In domiciliary barracks the same type of low bed specified for use on hospital wards will be provided for epileptic beneficiaries. In general, forms of occupational therapy requiring the use of machines or edged tools are contra-indicated for epileptic patients.

(B) Observation of - Claimants or beneficiaries admitted for study to determine the identity and frequency of alleged convulsive attacks, must have continuous, careful observation. The ward physician or, in his absence, the officer of the day will be immediately summoned upon the appearance of any paroxysmal attack in the claimant or beneficiary so that full notes may be made, not only of the character and duration of the attack, but of the post-convulsive state (e.g., amnesia, mental confusion, Babinski reflex, eye and tendon reflexes, lacerations of the tongue or other injuries). In the interval between convulsive phenomena, study will be made of all evidences of congenital defects, scars, alterations of personality, egocentricity, irritability with violent tendencies, manifestations of mental dulness, thinking disorder, memory impairment, and general intellectual enfeeblement, characterized by plateau speech, circumstantiality, etc. The mental age or psychological level should be determined and careful inquiry made regarding transitory mental or interparoxysmal psychotic states, such as dazed reactions, anxiety, fears, fugues, impulsions, ecstatic states, religious exaltations, excitement episodes, etc.] (June 15, 1943.)

[6199 and 6200 canceled June 15, 1943.]







## OFFICER OF THE DAY

6201. HOW ASSIGNED.--(A) At every facility under direct and exclusive jurisdiction of the Veterans Administration, there will be assigned, daily, and according to the clinical type and number of patients, and the number of and distances between buildings, a physician or physicians of the full-time staff, to serve as officer or officers of the day. At all facilities with a standard bed capacity of 500 or less, one such officer will be assigned. At facilities primarily for general medical or surgical, and for tuberculous patients, having a standard bed capacity of more than 500 and less than 1,000, one regular officer of the day will be assigned and one assistant officer of the day will also be designated. However, where different clinical types of patients (general, tuberculous or neuropsychiatric) are housed in buildings separated by extensive distances, an additional regular officer of the day may be assigned for such separated building or buildings, if deemed essential. At facilities primarily for general or for tuberculous patients with a standard bed capacity of 1,000 or more, two regular officers of the day (one senior, one junior) will be assigned, and an assistant to them will also be designated. However, where, at these facilities there are two or more widely separated buildings, housing different clinical types of patients, an additional officer of the day may be assigned any or all such detached buildings, if determined necessary. At neuropsychiatric facilities with a standard bed capacity of more than 500, one regular officer of the day will be assigned, and one assistant officer designated. At neuropsychiatric facilities with a standard bed capacity of 1200 or more, the assistant will be assigned as a regular (junior) officer of the day in association with the regularly assigned (senior) officer, on Sundays and holidays, because of special need on such days to handle visitors, etc.

(B) The manager, upon advice of the chief medical officer or clinical director, will detail any full-time physician (including any chief of service, roentgenologist, pathologist, eye, ear, nose and throat or any other specialist) to act, in rotation, as officer of the day. When a physician has just completed some overtime work and has had no adequate rest therefrom before his scheduled tour of duty as officer of the day is to begin (as when the chief, surgical service, or any of his force was engaged in an emergency operation late the night before), the officer of the day next in rotation will be substituted, and the excused physician will take the tour of duty that had been scheduled for his substitute. Recuperation from illness will be sufficient reason for temporary deferment from duty as officer of the day, for a determined period.

(C) An associate physician will not be detailed as sole officer of the day unless he has rendered at least six months satisfactory service in his regular duties; but an associate physician who has not completed six months regular service may be assigned as assistant officer of the day, under the immediate supervision of a physician of higher grade who is assigned as the regular officer of the day.

(D) The name or names of the physician or physicians detailed as officer of the day and assistant officer of the day will be posted on the day preceding that on which he or they are to serve. The tour of duty of a regular or assistant officer of the day - which will be for 24 hours - will commence at an hour to be designated, at which time he will meet the officer or officers to be relieved, in the office of the manager, to receive instructions. When more than one regular officer of the day is



assigned, each will clearly be informed as to what buildings, wards, etc., will be visited by him. The outgoing officer or officers will return all keys that had been supplied by the manager, which should include keys to ward records and records in the office of the clinical clerk, keys to the pharmacy, and any other keys that may possibly be required. A written report will be delivered to the manager of the concluded detail, such as the hours the various wards were visited; deaths, elopements or accidents to patients or personnel; emergency treatment rendered; admissions made; fires; neglect of duty by employees; defects in messes; unnecessary lights or noises, and other happenings requiring report.

(E) An officer or assistant officer of the day will not leave the facility reservation during his 24-hour tour of duty except with permission of the manager, for sufficient cause shown. The manager will detail a substitute for the period of such permitted absence. The officer of the day, during his rounds, will keep in touch with the central telephone operator, so that he may be promptly located at any time. He will promptly attend to all calls. A regular officer of the day, when not making rounds, will occupy the hospital room that is provided for the purpose. So far as is possible, the same arrangement will apply to an assistant officer of the day; but when such accommodations are lacking, an assistant officer of the day will remain in his quarters, subject to call.

(F) The report made by an officer of the day when relieved will be retained in a manila folder, created for such reports, for thirty days, at the end of which it may be destroyed at the station, unless further custody of it is made necessary because of an inquiry or investigation ] (June 25, 1943.)

6202. GENERAL DUTIES.--[The officer of the day will make the ordered rounds of buildings and grounds. During his afternoon tour he will visit all wards and ascertain from ward physicians what patients will probably require attention during the night. On his night tour he will observe whether guards connected with hospital activities are alert and at their posts, and that night nurses and attendants are satisfactorily attending to their duties. He will visit restless, delirious, and seriously and critically ill patients, rendering such emergency treatment as is indicated, and recording the time and nature of such treatment over his signature on the clinical records (treatment and progress notes, Form 2614j). When the condition of a patient requires, he may order special nursing or attendant service for him. He will arrange privacy for dying patients. He will assure himself that all patients are receiving proper attention; will note whether the wards are properly heated and ventilated; that the water supply is cut off, if necessary to prevent freezing of pipes; will extinguish unnecessary lights and quiet any disorder or unnecessary noise. He will caution employees in regard to fire risks and, in the event of fire, will immediately take charge until arrival of the fire marshal, taking measures in the meantime to sound the alarm and extinguish the fire. He will be free to consult with and secure the assistance, when needed, of another officer who may be associated in the day's tour of duty; or may call the ward physician concerned; or, in accidents resulting in loss of life or requiring major surgical intervention, he may call the clinical director or chief medical officer or chief of service. He will especially assure himself of the safety of any neuropsychiatric patients who are under surveillance because of suicidal or elopement tendencies; will arrange needed ward transfers of acutely disturbed psychotic patients; and will inquire into the custody of keys to doors, closets, medicine cabinets, etc. He will caution attendants to keep under observation restless psychiatric patients and those visiting ward toilet rooms.] (June 25, 1943.)



6203. ACTING IN THE ABSENCE OF OTHER OFFICERS.--[The officer of the day will act as admitting officer in the absence from duty of the chief, reception-outpatient service or other physicians of that service, and will be familiar with the procedure applicable in emergency admissions (see R. & P. 6039, Requests in Person for Hospital Treatment or Domiciliary Care, and R. & P. 6078, Emergency Admission for Hospital Treatment). He will direct custody of clothing and luggage of the patients admitted by him; and will take into his possession the funds and valuables of such patients, for delivery, upon conclusion of the tour of duty, to the manager, who will turn over the funds to the agent cashier and the valuables to the supply officer. A receipt will be supplied the officer of the day by the manager. The officer of the day will confiscate all articles (weapons, alcoholic beverages, narcotics, medicines for self-administration) which are forbidden introduction. He will carefully examine unconscious or psychotic patients whom he admits, noting evidences of alcoholic or drug intoxication, bruises, wounds, fractures, dislocations or other marks of violence. He will arrange isolation for patients with communicable disease. He will render any emergency treatment necessary for patients admitted by him, and other beneficiaries who require medical attention, and he will record his physical examinations and treatments in the patients' clinical records.] (June 25, 1943.)

6204. PARTAKING OF COOKED RATIONS.--[The officer of the day will eat three meals in the patients' general mess. When possible, it is preferable that these be eaten before the patients are served, thus allowing him to be free to inspect the general service of the meals to the patients. The meals eaten will, in respect of quality, quantity and preparation be identical with those served the same day to the patients. No charge will be made for these meals eaten by the officer of the day except that if subsistence is provided for in his contract of employment, no adjustment will be made for the meals eaten by him during his tour of duty as officer of the day as would be included in his contract of employment.] (June 25, 1943.)

6205. [ACTION IN DEATHS OF PATIENTS.--When death of a patient occurs in the absence from duty of a ward physician, the officer of the day will supervise the removal of the body to the facility morgue. He will detach the identification tag (Form 2596) from the foot of the patient's bed and attach it carefully to the right wrist of the body, where it will remain until the body is fully prepared for burial or shipment. He will collect all money, valuables or other personal effects that were on the person or in the possession, on the ward, of the deceased patient, and will carefully guard these for delivery, upon conclusion of his tour of duty, to the manager or his designate, who will turn the funds over to the agent cashier, and the valuables and other effects to the supply officer. The head attendant will be notified at the time of the death, to arrange carriage of the body to the morgue, as will the clinical clerk upon coming on duty. When autopsy is refused and the cause of death is not reasonably clear enough to justify execution of the death certificate (especially if violence, self-inflicted or inflicted by others, is suspected), the circumstances will be brought to the attention of the chief medical officer or clinical director as soon as either comes on duty, for notification of the coroner of jurisdiction; and action, including performance of an autopsy, will be taken in accordance with the coroner's instructions. If shipment of the body of a deceased beneficiary is to be made after regular hours, the officer of the day will act as inspecting physician of the preparation of such body, if accomplished at the facility, and will execute the prescribed reports thereof.] (June 25, 1943.)



6206. [MESSAGE IN CRITICAL ILLNESS OF A PATIENT.—(A) The officer of the day, in critical illness of patients at night, is authorized to send a brief official telegram, so notifying the nearest relative or other person to be informed in an emergency, as shown by the Clinical Record Brief, Form 2614a. This notification will be in accordance with station form devised for this purpose. The officer of the day will be expected to exercise due discretion in this, since often, owing to lateness of the hour, telegrams cannot be forwarded until morning, when they can then be sent by the manager. When a post office box number only is used as the address of a telegram and the postmaster does not know the street address, so that the local telegraph office cannot effect delivery of the telegram, it is not the practice of telegraph companies to notify the sender of the non-delivery of his message. Therefore, a post office box will not be used as the address of a telegram if any other information is available. Whenever a post office box address is the only one available, there will be added in the telegram "or other local address" and, at the bottom of the message, "Promptly notify sender if not delivered." These telegrams will be sent only to nearest relatives, guardians, etc., who reside in the continental limits of the United States.

(B) Instead of a telegram, notice of critical illness may be communicated by telephone, if the situation requires.] (June 25, 1943.)

6207. MESSAGE UPON DEATH OF A BENEFICIARY.—[(A) Except when communication is by telephone, or funeral arrangements are made through an interview, as hereinafter provided, a telegram or radiogram (priority), worded as follows, will promptly be sent upon death of a hospitalized patient or domiciled member, to the surviving spouse, if any, or to the next of kin, if any, or to the nearest friend, in that order. This message will be dispatched by the officer of the day if the death occurs during night hours, and by the manager or assistant or acting manager, if the death occurs during day hours. It will be sent only when any such addressee resides within the continental limits of the United States; or in Alaska, when the decedent had been brought from Alaska for hospitalization within the continental limits of the United States. This message will not be sent if any such proposed addressee is visiting at the facility at the time of death. The Clinical Record Brief, Form 2614a, or Finance Form 1170, Designation of Person to Receive Personal Effects, filed with the Form P-10 in the facility correspondence file related to the decedent, will be consulted for names and addresses:

(Facility and date)

(Name and address)

Deeply regret to inform you that your

(Relationship)

died

(Name of deceased beneficiary) (Day and hour)

Complete burial may be made at Government expense in cemetery this facility, in national cemetery at \_\_\_\_\_ or any other national ceme-

(Nearest national cemetery)

tery, or body can be shipped at Government expense to place named by you. If Government prepares body for shipment approximately \_\_\_\_\_ will be available

(Dollars)

for expense of interment plus reasonable charge for removal from depot to residence or



mortuary and cemetery, provided duplicate payment is not made from other sources. If Government services not desired, reimbursement actual expenses not exceeding one hundred dollars plus certain cost of transportation may be allowed. Permission for scientific examination of body requested. Wire instructions collect by \_\_\_\_\_, otherwise Government will proceed with preparation and (8 hours after sending time) burial of body.

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(Manager)

(1) Punctuation marks will not be used on messages to go wholly or in part by Army or Navy radio.

(2) The phrase "in cemetery this facility" will be omitted if there is no cemetery on the reservation of the facility concerned.

(3) The phrase "in national cemetery at \_\_\_\_\_ or any other national cemetery" will be omitted if the decedent's discharge from military or naval service had been anything other than honorable. The answer to question 2, Form P-10, which should record the entire service of the applicant in the armed forces, including character of discharge, should be consulted. It is to be remembered that, under R. & P. R-6047 (E), an applicant may be supplied hospital treatment or domiciliary care, other eligibility provisions being met, if he had been "not dishonorably discharged" from war service.

(4) The figure to be inserted in the space above "dollars" will be furnished by the supply officer at the beginning of the fiscal year.

(5) The request for autopsy ("scientific examination of body") will not be incorporated unless the conditions governing such requests are met. (See permission for autopsies). Regard must be had to the statutes of the State in which the facility is located in respect to persons who may consent to performance of an autopsy; only a surviving spouse or next of kin is so authorized in certain states, and consent cannot be given by a former guardian or friend.

(6) When the surviving spouse, next of kin or nearest friend, as provided, resides in or near the location of the facility, communication should be had with him or her by telephone, if possible, rather than by telegram or radiogram. Full information in conformity with the terms of the telegram, will be imparted and definite arrangements made; or he or she can be instructed to call at once at the facility, where matters can be concluded. A short but clear summary of the agreement as to the arrangements thus made, signed by the spouse, next of kin, etc., will be placed in the correspondence file of the deceased beneficiary, following such interview at the facility.

(7) When death can be anticipated sufficiently in advance, as in terminal cases, a letter, incorporating full information and requesting instructions as to disposition of the body after the expected death occurs, will be sent to the surviving spouse, next of kin, or nearest friend, instead of the foregoing telegram. If the spouse, etc., lives reasonably near the facility, it can be suggested that he or she visit the facility to discuss the matter.

(8) If a surviving spouse, next of kin, or nearest friend, as provided, is at the facility when the patient is dying, or at the time of his death, instructions as to the desired disposition of the body can be then procured, and no messages by telegram, radio or telephone will be needed. In the correspondence file related to the decedent will be placed a summary, signed by the spouse, etc., of the arrangements so agreed upon.

(Par. 6207 Cont'd)



(9) The hour specified in the telegram, that is, "eight hours after sending time" of the dispatch, is the maximum period the body will be held if reply to the telegram is not received by that set hour. If reply is made to the telegram at any time within eight hours after it is sent, the expiration of eight hours will not be awaited but action will promptly be taken in accordance with instructions in such reply.

(B) Message upon death of a beneficiary whose nearest relative resides outside of the United States.--(1) Upon the death in a facility of the Veterans Administration of a beneficiary whose surviving spouse or next of kin resides outside the continental limits of the United States, that is, in an insular possession or territory (except as provided regarding Alaska, in (A) hereof), the following telegram, radiogram or cablegram, as necessitated, will be dispatched, by the manager of the facility, to such spouse or next of kin.

\_\_\_\_\_  
(Facility and date)

\_\_\_\_\_  
(Name and address)

Deeply regret to inform you that your \_\_\_\_\_  
(Relationship)

\_\_\_\_\_ died \_\_\_\_\_  
(Name of decedent) (Day and hour)

He was buried in \_\_\_\_\_ at \_\_\_\_\_  
(National or facility cemetery) (Location)

with military honors. The Reverend \_\_\_\_\_ conducted \_\_\_\_\_  
(Name of clergyman)

\_\_\_\_\_ burial services.  
(Protestant, Catholic, Jewish)

\_\_\_\_\_  
(Manager)

(2) The wording of this message may be modified as regards military honors or religious service, attendance of a representative of the Veterans Administration, etc., to accord with the circumstances that obtained.

(3) The letter confirming this message (see deaths of beneficiaries) will be sent as soon as possible.

(4) Upon death in a facility of an ex-member of the military or naval forces of the United States whose surviving spouse or next of kin is resident in Canada, the procedure will be as prescribed herein for insular possessions and territories of the United States.

(5) When the next of kin resides outside the continental United States, but a responsible person, less closely related, living in the continental United States, asks release of the body for private interment, the circumstances will be communicated to central office by telegram or radiogram, with request for instructions.

(6) When the surviving spouse or next of kin of the deceased beneficiary resides in a foreign country other than Canada, the foregoing message will not be sent. Instead, a letter drafted as provided in R. & P. 6285 (see deaths of beneficiaries) will be mailed as soon as possible after the funeral.



(7) A copy of the telegram, radiogram or cablegram, and of the confirmatory letter, will be inserted in the facility correspondence file of the deceased beneficiary, as will a copy of any letter sent to a foreign country, as provided in (6) hereof. The death certificate will be forwarded to the office having adjudicative jurisdiction over death claims.

(8) When the death of a beneficiary occurs in a facility other than one under the direct and exclusive jurisdiction of the Veterans Administration, where he had been receiving authorized treatment, the manager of the regional office or facility with regional office activities of the territory in which such other facility is located, will be responsible for the dispatch of the messages and confirmatory letters called for under (A) and (B) hereof.】 (June 25, 1943.)







## MEDICAL SERVICE

6209. CONDUCT OF.--In those larger facilities where organization of services is authorized, the personnel of the medical service, under immediate direction and supervision by its chief, will be responsible for the efficient diagnosis and treatment of patients with general medical disorders. The chief, medical service, will be available for consultations with physicians assigned to his wards, and he or any member of his service whom he may designate will consult, as requested, with the chief, surgical service, or other officers. The chief, medical service, will confer with the chief medical officer or clinical director regarding the administration of his service. He and physicians of his service will present cases at clinical conferences of the hospital staff. Individual or group instruction will be imparted to patients, regarding the dietetic and hygienic regimen to be observed by them, during and after hospitalization. For the guidance of the chief dietitian, special diets will be prescribed for patients on this service, and careful attention will be given to discontinuance of special diets no longer necessitated. Transfers of patients from the medical service to other wards will be made in accordance with station procedure, as ordered by the chief medical officer or clinical director. The introduction and maintenance of modern methods of diagnosis and treatment, and preparation of full reports of physical examination and of satisfactory clinical records are prime requisites of this service. Physicians of this service will be required to prescribe the types of physical therapy to be administered by aides, and to authorize adjunct or auxiliary dental treatment. The chief, medical service, will give close supervision to these duties of his staff. (June 25, 1943.)

## SURGICAL SERVICE

6210. CONDUCT OF.--(A) The general duties of the chief of surgical service include supervision and direction and responsibility for all of its activities; conferences with the manager, chief medical officer or clinical director as to administrative policies and conduct of his service; consultations with chiefs of other services and with physicians of his own service as to diagnoses and treatments; performance of operations not delegated to his personnel; no operation will be performed except in an acute emergency without the specific authority of the chief of the surgical service; presentation by him or members of his staff of cases at clinicopathological conferences; transfer of patients to other wards in accordance with station procedure, as ordered by the chief medical officer or clinical director; general direction and supervision of preparation of physical examination reports, clinical records, and other reports of the activities of his service. His direction and supervision will extend to the surgical specialties - orthopedic, urological, eye, ear, nose and throat surgery and [to radium and X-ray therapy, if the station be equipped therewith. Oral and dental surgery will be under the general supervision of the chief medical officer or clinical director.] (March 28, 1944.)

(B) (1) The surgical service must be ready at all times to handle emergencies. Sufficient personnel will always be on duty to meet this necessity, and the operating suite kept in order to proceed without delay. Keys to the operating room will be in possession of a physician or nurse of the surgical service who is on duty, and such person will not be permitted to leave the station without consent of the chief or acting chief of the service, who will take over the keys or name the physician or nurse to whom they will be surrendered by the departing physician or nurse.

(2) An emergency lighting system will be installed to provide illumination for emergency operations in the event of failure of the regular electrical equipment.



(3) Infection of post-operative wounds will be investigated and appropriate measures taken to prevent such infections if the cause is disclosed. At periodic intervals, tests will be made of the mechanical operation and effectiveness of sterilizers and autoclaves in the surgical suite. The sterility of suture material, particularly catgut, and of gauze and sterile water will also be periodically checked.

(4) Except in emergencies when time will not permit of the precaution, a rigid inspection of surgical instruments, prior to their sterilization, will precede operative intervention. Besides this preliminary inspection all surgical instruments, especially pedicle clamps and hemostatic forceps, will be surveyed semi-annually, - January 15 and July 15, to determine their fitness for use. Instruments found un-serviceable and not fit for repair, replating etc., will be reported for replacement. (See Boards of Survey for Surgical Instruments.)

(5) There will be prepared, for the guidance of surgery personnel, clear, detailed instructions as to preparation of patients for operation, post-operative care, care of emergency conditions, head injuries, etc. The responsibility of each employee for his or her part of these duties will be defined. The nurse in charge of the patient's ward will be made definitely responsible for procuring his pre-operative preparation and particularly for evacuation of his urinary bladder and bowels before he is sent from the ward to the operating room. A notation will be made on Form 2614k, Nurse's Progress and Treatment Record, of the fact that the urinary bladder of such patient was so evacuated, the manner of evacuation (voluntary voiding or catheterization) and the amount of urine so obtained. Catheterization, if necessary, will be performed by a physician. The nurse in charge of the surgical suite (preferably a head nurse, in larger facilities) will be relieved from night duty (except in emergency night operations), and will be assigned continuously to the surgical suite until relieved. She will be made responsible for the direction of nurses under her, the preparation of instruments and dressings, and supervision of the operating suite during and between surgical operations. She will direct the cleaning-up of the operating room, as soon as possible after conclusion of operations. Her assistant, who will be the scrub nurse, will be thoroughly trained by the nurse in charge, so that she may serve as nurse in charge in the absence of the latter. The chief of surgical service may make either the nurse in charge or her assistant responsible for the sponge count at each operation; that will be made and recorded, even if not called for by the operating surgeon. The chief nurse of the facility, in cooperation with the chief, surgical service, will assign nurses in rotation and in sufficient number, from time to time, to the surgical suite for training, to serve in the absence of the nurse in charge or her assistant. The staff nurses provided such training should be selected for aptitude.

(6) Not later than 2 p.m. the day preceding (except in emergencies), the chief, surgical service, will have prepared by the clinical clerk a schedule of the next day's proposed operations, showing the names, register numbers and C-numbers (if any) of the patients, the diagnoses, the side or sides of proposed operation in bilateral organs or parts (such as the testicles, kidneys, hernia, etc.) and anesthetics to be used. This schedule, after being carefully checked for accuracy by the chief, surgical service, (particularly as to the side or sides of operation in bilateral organs or parts, and as to identities of the patients) will be posted by the clinical clerk, and copies distributed by that clerk to the chief, surgical service, the chief medical officer or clinical director, chief nurse, nurse in charge of the surgical service, chief of laboratory service, cardiologist or other physician responsible for heart examinations before operations, and the information clerk. The clinical



records of the patients scheduled will be examined by the chief, surgical service, in making his check as to accuracy of the schedule; and if there is the slightest doubt as to identity of a patient listed or as to the side or sides to be operated upon, he will confer with the ward physician concerned. The clinical records of all patients listed on schedules will be sent to the operating suite at a time well before operations are begun, for reference as needed, and will be returned to the wards with the respective patients. Any drugs administered in the operating room will be recorded in these clinical records. (June 25, 1943.)

(7) A urine specimen of all patients scheduled will be sent to the laboratory, not later than 2 p.m. of the day before the proposed operation. If it be impossible to obtain the specimens before that hour, the night nurse in charge of the patient's ward will obtain a specimen of the next morning's urine and forward it at once, labeled "Special - operation scheduled today" to the laboratory, where examination of such specimen will be made at once [and reported without delay. Coagulation tests of the blood of patients scheduled for operation will be made the day previous to operation; in emergent surgical intervention, they will be made before the operation.] A cardiologist or other physician designated by the chief medical officer or clinical director for such regular duty will carefully examine the heart and lungs immediately before any patient is to be operated upon, under a general or spinal anesthetic, or for a major operation under local or regional anesthesia. In surgical intervention of a minor character, with or without a local anesthetic, a certification by his ward physician that the surgery is not interdicted will suffice. If examination of the heart and lungs reveals any condition which in the opinion of the examiner makes operation entirely contraindicated, or advisable only under a local anesthetic, he will accordingly inform the chief, surgical service, or other member of the surgical staff concerned. Reports from the laboratory as to urine examinations and blood coagulation tests will promptly be forwarded to the chief, surgical service, before the hour set for operation; and thereafter, together with the report of examination of the heart and lungs, will be incorporated in the clinical records of the patients. (March 28, 1944.)

(8) Consent to surgical operation will in every case be obtained, from the patient if competent; or from the guardian or nearest relative if the patient be mentally incompetent or unconscious, or be a minor (other than a minor member of the armed forces in active service, referred by a military or naval officer for medical services by the Veterans Administration).

(9) The identity of the patient and the identity of the organ or side requiring operation (in orchidectomy, hernial repair, etc.) must be established beyond doubt before proceeding with an operation. This rule extends to absolute assurance of the identity of a patient before spinal puncture.

(10) The operation findings and the post-operative condition and treatment of patients must be reported to the chief medical officer or clinical director, so that relatives may be given such information, by letter, telegram or through the information clerk, as is indicated or requested.

(11) All specimens removed at operation will be promptly forwarded to the laboratory for examination, properly identified by name, ward, bed, number, register and C-number (if any) of the patient, and the date and hour of operation. Limbs, organs or tissues which are to be incinerated will be taken to the furnace, after careful packaging, by a hospital attendant, who will remain until the package has been placed in the furnace.

(C) The surgeon performing the operation will be personally responsible for avoidable surgical accidents due to faulty technique or lack of due precautions, as in retained sponges or instruments.



(D) No visitors, whether physicians or lay persons, including relatives of patients who are to be operated upon, will be allowed entrance to the surgical suite except with permission of the chief, or acting chief of surgical service. Any person so permitted to witness a surgical operation will be clothed in a sterilized gown and cap, and a nose-and-mouth mask.

(E) The chief, surgical service, will enjoin economy in the use of supplies by his personnel. Catgut must be conserved: small tubes of this material will preferably be issued, and the 60-inch strands, which are usually cut into three 20-inch lengths for ligatures, can be divided into four 15-inch lengths; the extra 15-inch strand so created will make unnecessary the opening of another tube. Open only a part of the tubes of catgut that are assembled for an operation. The reserve can be opened, if and when needed, without delaying the surgeon. Stocks of surgical supplies on hand anywhere on the station should always be investigated before another requisition is placed for suture materials or other items. The stock of surgical needles should be closely inspected, and those with defective eyes should be discarded, as they are destructive to catgut sutures. The consumption of surgical gauze can be reduced by strict prohibition of its use for any other than its legitimate purpose. Proper sterilization of latex gloves and other rubber goods can accomplish economies in these articles. Such items should be placed alone in sterilizers, and not packed in with other articles. When sterilization is begun, the air in the sterilizing chamber should be displaced by steam as quickly and completely as possible. This can be done only if an abundant supply of steam is available and if the traps are clean and in good working order. The displacement of air can be speeded up by opening bleeder valves which by-pass the steam traps. After exposure to steam for the requisite period, the charge in the sterilizer should be dried as quickly as possible, with the minimum of exposure to air. The drawing of a vacuum in the sterilizing chamber immediately after sterilization is complete and the steam has been exhausted from the chamber, will accelerate the drying of the articles in the chamber. (June 25, 1943.)

6211. CHIEF MEDICAL OFFICER; CLINICAL DIRECTOR; CHIEF, TUBERCULOSIS SERVICE; CHIEF, NEUROLOGIC SERVICE.--For duties and responsibilities of these officers, see Specifications for Positions in the Field Service and Outline of Duties and Responsibilities of Field Personnel. (June 25, 1943.)

## LABORATORY SERVICE

6212. ORGANIZATION.--(A) A full-time pathologist will be assigned in facilities, whenever possible, to conduct the activities of the laboratories and the morgue, and he will be administratively designated as chief, laboratory service, but when the size of the facility does not justify the full-time services of a pathologist, a part-time pathologist may head the laboratory organization; or, if the services of a full or part-time pathologist are not obtainable or not necessitated, authority may be requested from the medical director to assign a physician of the staff, most qualified, to the position. In larger facilities the chief, laboratory service, will have charge of the clinical laboratory and morgue, in addition to his duties as a pathologist. In smaller facilities, besides those functions, he will have charge of the roentgenological laboratory, if a roentgenologist is not assigned.

(B) DUTIES.--See Specifications for Positions in the Field Service. The chief, laboratory service, will be responsible for the procedure, work of personnel and equipment of laboratories, under supervision of the chief medical officer or clinical



director. Especial care will be exercised by him or by the roentgenologist, if one is assigned, to maintain X-ray apparatus in good working order. Adequate personnel will always be on duty to meet emergency needs for laboratory service of any kind. The chief medical officer or clinical director will formulate station orders governing the utilization of the laboratorian's services, by the staff, including bedside procedure. Arrangements will be made whereby telephonic report can be had from the roentgenological laboratory based upon interpretation of the wet film, followed by confirmatory written report after the film has dried. It is essential that spinal fluid specimens be delivered to the laboratory immediately they are withdrawn, as trustworthy cell counts and globulin determinations cannot otherwise be made. The chief, laboratory service, will attend all clinico-pathological conferences. He will supply the chief medical officer or clinical director with the names of personnel under him who will be available for laboratory service after regular hours or on Sundays and holidays. For his duties regarding blood donors, transfusions, etc., see R. & P. 6140. He will be responsible for all bodies of deceased beneficiaries from the time they reach the morgue until they are ready for burial or shipment. He will have charge of the performance of all necropsies, preparation of protocols pertaining thereto, and the preservation, classification and disposition of pathological material. Complete records of each autopsy will be made on Forms 2614n, n-1 and n-2, clinical records. If material is being submitted to a laboratory center (see R. & P. 6061), a copy of such records will be forwarded therewith. (June 25, 1943.)

6213. ANALYSIS OF DAIRY PRODUCTS AND WATER.--【(A)】 The purity of dairy products and water used at facilities is essential, and chemical and bacteriological examinations of milk, cream, ice cream and water will be made at appropriate intervals to establish their quality. Water will be examined for the number and kind of contained bacteria; its chemical examination will be made only as indicated. Careful supervision will be made to protect the water supply against possible contamination. When such contamination is suspected, prompt report with recommendations will be made to the medical director, for reference to the director of construction. Analysis of water, milk, cream and ice cream will be in accordance with the standard methods of the American Public Health Association. When a State or city board of health or any other Government agency will make chemical or bacteriological examination of dairy products or water without charge, such service will be accepted and duplicate examinations need not be made by the Veterans Administration, but copies of such reports from outside agencies will be filed at the facilities requesting the service. 【 】

【(B)】 Laboratory examinations of milk, cream and ice cream purchased for use at the station shall be made at least once a week to determine the percentage of butter fat and the bacteria count. Should delivery of an undergrade product be discovered, laboratory examination shall be made of each succeeding delivery until it is shown by three consecutive examinations that the contractor is delivering the grade of produce required by the specifications. Results of examinations of milk, cream, and ice cream made by a laboratory of a facility will be recorded on Form 2650 in duplicate.

(C) Copies of reports of examination of dairy products submitted by a State or a city board of health or any other Government agency and copies of Form 2650 reporting examination of dairy products will be forwarded promptly to the supply officer through the chief medical officer or clinical director for adjustment of payment to the contractor in accordance with the provisions of paragraph 16, General Conditions, Standard Specifications for Packing House and Dairy Products, if indicated, and contact with the contractor, apprising him of the facts and insisting upon immediate correction.



(D) All reports of laboratory examination of dairy products and water will be retained until the next visit of central office supervisors. They may then be recommended for destruction and disposed of in accordance with approved procedure for disposal of inactive records.]

[(E)] The examination of butter made by inspectors of the United States Department of Agriculture, together with organoleptic inspections made at the facilities will be sufficient to justify acceptance of butter so inspected, and chemical and bacteriological examinations of butter will not be required.

[(F)] Facts regarding any epidemic prevalence of disease, of suspected or proved origin in infected water, dairy or other food sources will promptly be reported, with recommendations, to the medical director. (September 9, 1944.)

6214. CUSTODY AND APPLICATION OF RADIUM.--CUSTODY: Radium element, which is always in combination as a salt (chloride, bromide, sulphate, carbonate, etc.,) in suitable containers, when not in use, will be kept in a steel safe (except in the case of a radium cannon or bomb, or a radium emanation apparatus as described below) lined with lead, never less than 5/8 inch, and not more than 1 1/4 inches in thickness, if the amount of radium exceeds 100 milligrams (this may be a properly constructed lead box instead of a full lining).. This safe will be placed in a properly selected location on the ground floor, as far as practicable from all regularly stationed personnel and other than transient patients. The safe lock may be of key or combination type, preferably the latter. If of key type, the lock must be unique, opening to no other key on the station, and will have but two keys - one to be kept in possession of the radium custodian, acting radium custodian, or properly appointed assistant; and the other in a sealed envelope, typed with the legend "Key to Radium Safe", to be kept in possession of the station head. If the safe lock be of combination type, the combination formula will be known only to the radium custodian, and/or acting radium custodian, or properly appointed assistant, and copy will be sealed in an envelope typed "Combination to Radium Safe" and left in possession of the station head.

A radium bomb or cannon or pack, as it is variously termed, consisting of a lead cylinder of wall thickness proportional to the amount of radium contained, will have the radium locked into the bomb by an effective device to give the desired r.s.d. (radium skin distance). When not in use the cannon will be "turned off" or locked into a heavy lead cover, which serves three purposes: to obstruct effectively and reduce the gamma radiation; to increase the weight of the cannon; and to prevent removal of the radium by unauthorized persons. The bomb will be under the direct supervision and care of the radium custodian, acting radium custodian, or properly appointed assistants.

A radium emanation apparatus, consisting of a safe to hold the radium and two Toepler-mercury pumps with a purification chamber between them (in duplicate), will be placed in a room selected for the purpose, with unique lock and keys provided for the radium custodian, and/or acting radium custodian, and assistants at the discretion of the officer in charge. The combination to the safe will be in the possession of the radium custodian, and a copy will be sealed in an envelope typed "Combination of Radium Emanation Safe", kept in possession of the station head. This safe will be kept locked at all times, except for inspection of radium flash or repairs. The radium emanation apparatus will be under the direct supervision of the radium custodian, and will be operated by at least two properly trained technicians.

The technician on duty will keep a record of each pumping of the radon as instructed by the radium custodian. This record will show the disposition of the radon, what containers were used, and also the number and estimated strength of gold implants, if any were made. Not less than 3 hours later, when approximate (96.3%) equilibrium is established between the radon and the active deposit of short life, the products of the day's pumping (tubes, implants, etc.,) will be measured by the technician with a gamma ray electroscope, and a complete record of these measurements kept in books designated for the purpose - one for tubes, bulbs, etc., and one for gold implants. After the completion of these measurements the date and times and strength of each container will be entered in record books (one for gold implants and one for tubes, bulbs, etc.,) and the decay values entered each day at the times designated by the radium custodian.

The radium custodian will be a physician properly qualified and experienced in radiation therapy, nominated by the station head after full consideration of his qualifications. He will be responsible for the custody of radium element and other radioactive substances at the station, and also for keys and combinations to radium safes and compartments. In case of illness of the radium custodian or his absence  
(6214 continued)





on leave for a period exceeding 48 hours, during which time radium or other radioactive substances are expected to be used, the station head will appoint an acting radium custodian, who will assume the responsibilities and duties of the regular radium custodian. Upon transfer or separation from the service of the radium custodian, the station head will appoint a physician of the hospital staff to this position, who will assume full duty and property responsibility, after a complete accounting of all radium element and radioactive substances. This accounting will also apply in case of illness or leave of absence exceeding 48 hours of the radium custodian. In addition, a regular monthly inspection of the amounts and conditions of custody of the radium or other radioactive substance, appliances, records, etc., will be made by the station head or physician designated by him.

**RELEASE:** Radium element or radon (as gold implants) will be released by the regular or acting radium custodian or properly appointed assistant to the physician presenting the original and a copy of a requisition form, in which will be named the bearer, the number and amounts of units and kinds of appliances desired, to be signed by the station head, clinical director, chief of surgical service, or chief of cancer clinic. The regular or acting radium custodian or properly appointed assistant will record, on the original and copy, the number and amounts of units and kinds of appliances supplied (stating "In full as requisitioned" or noting any differences between what is requisitioned and what he is able to supply), enter the hour of release, secure the signature of the recipient, give him the copy, and retain the original requisition. The operator, upon completing the use of the radium or radon will promptly return it with the copy of the requisition, noting upon the latter the name or names of patient or patients treated. Upon return to him of the material, the regular or acting radium custodian or properly appointed assistant will check the number and amounts of units and kinds of appliances returned against the notations on his retained original of the requisition and, if they correspond, will sign his name, and the hour of return upon both the original and copy of the requisition, both of which he will then retain. All gold implants will be returned by the operator to the regular or acting radium custodian or properly appointed assistant, to conserve the gold.

In the event the regular or acting radium custodian is the only person authorized to apply radium element or other radioactive substances for treatment, he will execute the prescribed form faithfully as a matter of record. He will keep a daily record, in a book designed for the purpose, of the use of radium element or radioactive substances, noting the actual daily releases in detail, as shown by his retained requisition forms. In the event no radium element or other radioactive substance has been released on a given date, this entry will be made in the book: "No radium element or other radioactive substances released this date." This daily record book will always be kept accessible by the radium custodian for inspection by the station head, or in his absence, the clinical director.

**PRECAUTIONS IN TREATMENT.**—Patients will be assigned to a room especially designated for radium treatment (patients receiving radon application may remain in their own rooms). They will not be permitted to leave this room, (in which all necessary conveniences will be supplied), except in extreme emergencies, and then only when accompanied. Upon conclusion of each treatment the operator will personally collect each item of radium element or other radioactive substances. No article of clothing equipment, etc., will be removed from the room, nor will any assistant or assistants, if present, be permitted to leave the room, until the operator has collected every item of radium element or other radioactive substance issued upon the requisition. (Par. 6214 Cont'd.)



**APPLICATORS.**--All radium applicators used for treatment will be properly tagged with a label written in red type - "CAUTION. RADIUM. DO NOT THROW AWAY." Needles inserted into tissues will have ligatures attached (wire, silk, or catgut), the loose ends of which will be firmly fixed to the skin with adhesive strips. A pre-printed tag will be securely fastened to the outside of the dressings, upon which will be clearly stated the amount of radium element or other radioactive substance employed, the number of tubes or other applicators used, the location of the applicators with regard to the lesions and the bandage layers, the time the radium element or other radioactive substance was supplied, and the time it is to be removed. The same instructions will be copied on the patient's treatment record, Form 2614j, and the ward nurse's attention invited to the notation, with orders that, on going off duty, she will direct attention of her successor thereto.

The dressings will be removed, whenever at all possible, by the physicians who applied the radium element or other radioactive substance, and they will be held intact and at the site of the removal, until all radium units used are found, checked, and accounted for. If it is impracticable for the physician who applied the dressings to remove them, he will, upon completing the dressings with the directions tag, and making the notation on the treatment record, contact the officer of the day and give him written notice of the exact time the dressings are to be removed. The officer of the day, at the time set, will remove the dressings (including the directions tag) containing the radium element or other radioactive substance, and deliver them to the regular or acting radium custodian, who will check return against the data on the directions tag, and give a receipt for the return, as provided under **RELEASE** in the foregoing. If it is anticipated that the dressings will be removed at an hour when the regular or acting radium custodian will not be on duty, arrangements will be made with him, by the physicians who applied the radium or by the officer of the day serving for him, for delivery of the keys to the radium compartment. The radium or other radioactive substance, together with the dressings and direction tag, will then be deposited by the physician who made the application or by the officer of the day serving for him, intact, in the radium compartment, for check by the radium custodian as soon as he goes on duty.

**TREATMENT BY RADIUM EMANATION.**--Heads of stations so authorized by the medical director will be supplied with facilities for treatment by radium emanation (radon), either by arrangements for delivery of an agreed upon number of filled implants at convenient periodic intervals; or by direct radio request upon the Manager, Veterans Administration, Hines, Illinois, for such amounts of radon, specified in millicuries, as are needed from time to time. A memorandum specifying the number of filled implants, the total millicuries, and the date of fillings and sealing of the implants, will accompany each such shipment. The head of the station receiving such shipment will have the number of filled implants checked before application, and will inform the Manager, Veterans Administration, Hines, Illinois, of any apparent error in the count.

A millicurie of radon has the same initial gamma ray activity as a milligram of radium element; but, owing to the rapid decay of radon there is a falling activity that amounts to about 0.75 percent per hour, or approximately one-sixth in twenty-four hours or one-half in 3.85 days. This progressive reduction in potency through age of the radon will be considered by the operator of the hospital receiving shipments of radium emanations. (See stations having facilities for radium therapy).

So far as the safety of personnel and patients is concerned, radon will be handled and stored the same as is radium. (June 25, 1943.)



## DENTAL SERVICE IN FACILITIES

6215. [ORGANIZATION.--The dental service in a facility will be in charge of a chief dental officer, under the general supervision of a chief medical officer or clinical director. A chief dental officer will be responsible for the efficient functioning of the personnel assigned to his service; for dental examinations; for initiation of dental treatment and determination of the type and extent thereof; prompt completion of that treatment; maintenance of high quality of dental service; maintenance of required standard of asepsis and sanitation; the care of dental equipment and supplies; and the preparation of required reports and records, etc.] In facilities having regional office activities, he will also be responsible for the efficient conduct of out-patient dental activities. (July 15, 1943.)

6216. COOP-ERATION WITH CHIEF DENTAL OFFICER.--[To facilitate the conduct of his duties, the chief dental officer will be supplied regularly with a copy of the daily census report (see R. & P. 6111) showing admissions, discharges and transfers of hospital patients; and, at facilities having domiciliary accommodations he will similarly be furnished regularly with reports as to admissions, inter-company transfers, transfers to hospital and from hospital to barracks, and discharges and furloughs of members. Ward physicians will cooperate fully and promptly with the chief dental officer by approving or disapproving recommended dental treatment. Through the chief dental officer will be routed copies of laboratory reports showing positive serological tests for syphilis in beneficiaries receiving hospitalization or domiciliary care; and, if there are infective luetic lesions (chancres, mucous patches) in the mouths or throats or upon the lips of patients referred to him for examination or treatment, the referring physician will communicate this information to the chief dental officer.] (July 15, 1943.)

[6217.] APPOINTMENTS.--(A) At each facility there will be instituted a system of handling appointments for in-patients to report to the dental clinic for examination or treatment, as best meets the requirements of the particular station. When such a system has been adopted it will be rigidly adhered to. In the event that the chief dental officer experiences an unjustifiable number of broken appointments, he will report the fact to the chief medical officer or clinical director, whose duty it will be to take the necessary steps to correct the situation.

(B) In facilities wherein tuberculous beneficiaries are under treatment, selected patients not absolutely requiring rest should be referred to the dental clinic during the prescribed rest hours, so that the dental clinic may be kept occupied during such hours. Whenever possible dental examinations should be made, and 24-hour bed patients be given appointments during such hours.

(C) At facilities where domiciliary barracks are maintained, preference in making dental appointments will be given hospital patients who, having reached maximum benefit of treatment, are to be discharged. (July 15, 1943.)

[6218 canceled July 15, 1943.]

## DENTAL EXAMINATIONS

6219. DENTAL EXAMINATIONS.--(A) Patients admitted for treatment of tuberculous or neuropsychiatric disorders, where prolonged hospitalization is anticipated, will be routinely given a dental examination upon admission. Patients hospitalized for general medical or surgical disorders will ordinarily be given a dental examination



[When the admission diagnoses shown on the Form P-10 indicate the probable necessity of associated dental treatment. Chief dental officers will be routinely furnished a tissue copy of the Form 2614a from which they will determine whether or not a dental examination is indicated. Ward physicians may request dental examinations at any later period of treatment, when judged necessary because of recognition of another disorder or for other sufficient reason. Ward physicians when requesting a dental examination will advise the chief dental officer of patient's claim number, if any, register number, and service-connected status of his basic disability.]

(B) When a beneficiary upon admission for hospital treatment is to be given a dental examination, [the chief dental officer will arrange with ward personnel for his presence in the dental clinic. Should the patient not be ambulant, arrangements will be made for effecting the examination on the ward in accordance with such general instructions as may have been issued by the chief medical officer or clinical director.]

(C) Beneficiaries admitted for domiciliary (barracks) care will not be routinely given a dental examination upon admission. Dental examination of such beneficiaries will be made only if and when they apply for dental treatment, except that special dental examinations [may be made at any time when requested by a physician in attendance upon them. A member desiring dental treatment will be directed by his company commander to report at sick call, where he will be provided with a reference slip to the chief dental officer, showing his name, register number and barracks identification.] (July 15, 1943.)

6220. RECORDING DENTAL EXAMINATIONS.--(A) Dental examinations for hospital patients and domiciliary members will be recorded on one copy of the Dental Record, Form 2614p, of the clinical records series. The use of the same numerical nomenclature of teeth will be continued, and under the heading "Carious Teeth Nos." will be shown the numbers of the individual teeth, immediately followed by the alphabetical designation of the cavity location (example: 4-R; 5-V; 14-D-F). No space provided for making diagnoses must be left vacant, and captions showing degree of pyorrhea, gingivitis, etc., must be deleted in whole or in part to indicate conditions found in the mouth of the patient. If for example, there are no impacted teeth present, the word "none" will be entered in the space provided. [Dental radiographs will be interpreted and these interpretations recorded opposite "remarks," Form 2614p, or on a separate sheet, to be stapled to the beneficiary's Form 2614p. Any such separate sheet will be captioned "Interpretation of Radiograph," followed by the name, register number, C-number if any, and ward or barracks identification of the examinee, and the date of entries.] The name of the dental officer making the examination will be typed in appropriate space and the Form 2614p will be initialed by him. (July 15, 1943.)

6221. ACTION SUBSEQUENT TO COMPLETION OF ORAL EXAMINATION.--[After physical examination has been completed and definite diagnoses established, the chief dental officer will be promptly advised of the diagnoses which have been definitely established, together with information as to service-connected or nonservice-connected status of each disorder. He will keep close contact with the ward physician and/or clinical clerk so that no undue delay may occur in securing information as to the established diagnoses.] (July 15, 1943.)



## DENTAL TREATMENT

6222. [PROCEDURE IN AUTHORIZING.--(A) Promptly upon receipt of information as to the established treatment diagnoses, the chief dental officer will prescribe on Form 2614p the treatment indicated, in accordance with the principles of adjunct or auxiliary dental relief; or if he is of the opinion that associated dental treatment is not necessary he will note his opinion on that form.

(B) The Form 2614p will then be submitted to the treatment ward physician for determination as to whether the patient's physical or mental condition is such as to permit of rendering the prescribed dental treatment. If this determination is in the affirmative he will make appropriate notation on the form, sign his name, ward number and date, and return it to the chief dental officer. Should the ward physician be of the opinion that the patient in question is too ill at that time to be furnished the dental treatment indicated, he will so advise the chief dental officer on the Form 2614p and subsequently, when the patient has recovered sufficiently to permit of rendering the prescribed dental treatment, advise the chief dental officer to that effect. The chief dental officer will maintain a close follow-up on all Forms 2614p submitted to ward physicians, so that no undue delay in starting treatment may occur.

(C) If the ward physician disagrees with the opinion of the chief dental officer, he will request arbitration of the differences by the chief medical officer or clinical director, whose opinion will prevail. If the arbitrator agrees with the chief dental officer no further action will be taken. If he agrees with the ward physician the arbitrator will note his opinion on the Form 2614p, sign and date it, and return the form to the chief dental officer for completion of the authorized treatment.

(D) Upon the return of the Form 2614p upon which the ward physician approves of the furnishing of dental treatment, the chief dental officer will have these forms placed in the active treatment file, or in second section of the abeyance file, as may be appropriate. Should the ward physician desire the inauguration of treatment to be deferred, the forms will be placed in the first section of the abeyance file to be followed up from time to time, so that treatment may be started as promptly as possible.

(E) After examination of domiciled members (R. & P. §219 (C)), the chief dental officer is free to provide whatever treatment he determines necessary; a physician's certificate of necessity for such treatment, as an adjunct or auxiliary measure, is not required. The chief dental officer will record his findings upon the examination, and record treatment he authorizes by proper entries on Form 2614p. Thereafter, it will not be necessary for the member to report at sick call for dental treatment; he will report to the chief dental officer directly at hours appointed.] (July 15, 1943.)

6223.--TYPE AND EXTENT OF DENTAL TREATMENT FOR HOSPITAL PATIENTS.--(A) No differentiation will be made between the type and extent of dental [treatment] authorized as adjunct from that authorized as auxiliary. For general medical or surgical and for tuberculous patients the relief authorized will consist solely of such measures as may be reasonably expected to aid in the treatment and cure of the basic condition. (See Adjunct and Auxiliary Treatment.)



(B) For beneficiaries being furnished hospitalization in a facility devoted exclusively to the treatment of neuropsychiatric diseases, or in neuropsychiatric treatment wards in other facilities, who, it is anticipated, will remain under treatment for a prolonged period, the relief authorized will consist of such measures as may be considered reasonably necessary to keep their mouths in a clean and healthy condition, with sufficient dentition to enable them properly to masticate their food, regardless of expectation of improvement in the patient's mental condition. Replacements will be consistent with the patient's physical and mental ability successfully to use artificial appliances.

(C) Beneficiaries being furnished hospitalization for luetic disabilities, psychoses or psychoneuroses, except as indicated above, will be furnished only emergency dental treatment, unless they fall under the exceptions covering chronic cases requiring constant medical care, as defined in instructions relative to "intercurrent conditions," [provided that patients receiving intensive antisyphilis treatment may be provided the prophylactic dental attention necessary to insure continuance of that treatment].

[(D) Patients admitted for the treatment of acute or chronic alcoholism will be furnished no dental treatment other than emergency, unless it is determined that the patient has a definite psychosis and his retention in the facility over an extended period of time is contemplated.]

[(E)] If there is any doubt in the mind of the chief dental officer as to the feasibility of a neuropsychiatric patient successfully to wear removable artificial dentures, he will report the case in writing to the clinical director, who will present it at staff conference, and staff determination will be made as to whether dentures are to be furnished the beneficiary.

[(F)] Beneficiaries hospitalized for examination and observation will be furnished only such [emergency or intercurrent dental treatment as may be considered necessary by the ward physician to arrive at a diagnosis by elimination.]

[(G)] If artificial dentures worn by beneficiaries receiving authorized hospital treatment are accidentally broken to an extent that makes them useless, sufficient repair may be made, if feasible: Provided that such repair does not comprehend replacement of porcelain teeth on such denture, unless such number of them have been lost as seriously to interfere with proper mastication. Prior to attempting repairs chief dental officers will satisfy themselves that dentures were satisfactory as to fit prior to breakage, and that a satisfactory repair may be made. If these requirements are not met the repair will not be attempted. Dentures so broken as to preclude repair will not be replaced by new prosthesis unless duly authorized as adjunct or auxiliary treatment, or [for patients with chronic conditions requiring prolonged hospitalization]. (July 15, 1943.)

[6224.] TYPE AND EXTENT OF DENTAL TREATMENT FOR DOMICILED BENEFICIARIES.--Domiciliary members will be furnished whatever dental treatment including prosthesis, which, in the opinion of the chief dental officer, is reasonably necessary to maintain their mouths in a healthy, comfortable condition with sufficient masticatory surface to maintain health. Such measures will ordinarily consist of prophylaxis, fillings, extractions and denture replacements. Artificial replacement of lost natural teeth will not be made solely for cosmetic reasons. (July 15, 1943.)

6225. REQUESTS FOR DENTAL TREATMENT FROM BENEFICIARIES BEING FURNISHED HOSPITALIZATION OR DOMICILIARY CARE.--(A) If a beneficiary being furnished hospital [treatment applies directly to the dental clinic for treatment prior to authorization of



adjunct or auxiliary dental treatment for him, he will be informed that no dental treatment other than emergent (to relieve pain or infection) may be rendered him except when duly authorized as a part of the therapy of his basic disease. In such cases dental officers or ward physicians will express no opinion whether dental treatment is or is not indicated, or will or will not be authorized].

(B) If a beneficiary being furnished domiciliary care [applies directly to the dental clinic for treatment, the procedure prescribed in R. & P. 6219 (C) will be followed.] (July 15, 1943.)

6226. [CHANGES IN PRESCRIBED DENTAL TREATMENT.--After dental treatment has been prescribed by the chief dental officer, it will not be changed or modified except with his approval. Approved changes, if any, will be noted by the chief dental officer on Form 2614p and initialed by him.] (July 15, 1943.)

6227. RECORDING OF TREATMENT.--(A) As dental [treatment] is rendered from day to day, notation thereof will be made in the Dental Appointment and Record Book, Form 2679, from which record the dental assistant will daily make typewritten notations on the back of Form 2614p. The entries on Form 2614p will include not only completed operations, but also a record of what has been accomplished at each sitting, such as cavity preparations, impressions, post-operative treatments, etc. If there is insufficient space on Form 2614p for all entries necessary, additional forms will be used, which will be securely stapled or pasted to the first sheet.

(B) When the authorized course of treatment has been completed, a notation will be made on the line next following the last record of treatment, "Treatment Completed". If the beneficiary dies, is discharged, furloughed, [or absents himself without leave, etc., before authorized treatment is completed, whether or not any of the authorized treatment] has been rendered, a notation will be similarly made "Treatment Not Completed," adding the reason for non-completion of treatment, and the date of discharge, death, etc.

[(C) If the services rendered included the furnishing of artificial dentures, the beneficiary will be required to sign the following statement at the time the dentures are fitted: "I certify that artificial teeth have been supplied me this date (give date), and that they fit satisfactorily." If the beneficiary be mentally incompetent, this certification will not be executed.] (July 15, 1943.)

## DENTAL TREATMENT AS RELATED TO NEUROPSYCHIATRIC PATIENTS

6228. SPECIAL REQUIREMENTS.--(A) Tooth brush cabinets, constructed in accordance with specifications of Veterans Administration Blueprint No. 185, in sufficient number, or of sufficient size, to accommodate a tooth brush for each patient, will be located at some convenient place on each ward. Chief dental officers will, at least once a year, in a talk to nurses and attendants, give instructions with regard to proper supervision of brushing patients' teeth and the proper care of tooth brushes, and cabinets, and will, at irregular intervals, at least once a month, make personal inspection of brushes and cabinets to see that his instructions are being followed. He will report to the clinical director, in writing, any unsatisfactory conditions found.

(B) All hospitalized neuropsychiatric patients will be given a prophylaxis [at intervals of six months, or as soon thereafter as conditions will permit. This also comprehends those edentulous patients who are wearing dentures, who will have their dentures cleaned and polished. A dental officer will also check the fit of the



dentures, and determine whether they require adjustment, repair or replacement. At such times the dental hygienist will also call the attention of the chief dental officer to any dental defects found, and the chief dental officer will arrange such treatment as may be needed for such dental conditions.

(C) When a patient in a neuropsychiatric facility is given an appointment for routine prophylaxis, or other necessary dental treatment, the clinical record folder will be secured by the chief dental officer and the services rendered will be recorded on the last dental record sheet, Form 2614p, in the file. The clinical record folder will be promptly returned to the clinical clerk after it has served its purpose.

(D) Artificial dentures for neuropsychiatric patients will be marked with identifying symbols in series, beginning with A 1 to 9, then B 1 to 9, C 1 to 9, and so through the alphabet. When this first series is exhausted, the symbols will be changed to two letters, e.g., AA 1 to 9, BB 1 to 9, etc. Dentures worn by such patients upon their admission will be identified in the same manner. These symbols will be placed upon the inside of the buccal flange by inscription with a pointed stylus or No.  $\frac{1}{2}$  round burr. A ledger record of such identifications will be kept, showing entries of the dates of construction of the dentures or of the identification of a denture that was being worn, with the identification symbols and the patient's name and hospital register number.

(E) Artificial dentures found around the grounds or buildings of the facility will be delivered to the chief dental officer for identification from his ledger record, and for forwarding by him to the patient's ward physician. Such dentures will not be retained in the dental clinic.

(F) Neuropsychiatric patients who are to be discharged, transferred for domiciliary care at another facility, or granted trial visit, will be cleared by the chief dental officer. If any dental treatment for such patients has not been completed, the ward physicians will be so informed, and the discharge, transfer or trial visit will be postponed until the chief dental officer has notified the ward physicians of the completion of pending dental services.】 (July 15, 1943.)

#### ADJUNCT DENTAL TREATMENT AS RELATED TO HOSPITAL DISCHARGE

6229. 【DISCHARGED PRIOR TO COMPLETION OF DENTAL TREATMENT.--(A) When adjunct dental treatment (or treatment of a service-connected dental condition), consisting of extractions and replacement by a full or partial removable denture has been authorized, but it becomes necessary to discharge the patient before the dentures have been made or inserted, the chief dental officer will take the action necessary to insure the completion of the treatment on an out-patient basis by preparing a Form 2570 from the information contained on the Form 2614p, showing uncompleted treatment. In executing the Form 2570 the chief dental officer's certificate on the face of the form will be filled in.】 If the facility in question includes regional office functions, and the patient comes under the jurisdiction of the facility, the chief dental officer will proceed to authorize the completion of the treatment on an out-patient basis, either through the medium of a Veterans Administration clinic or a designated dentist, as may appear preferable. If the facility in question does not include regional office functions or the patient does not come under the jurisdiction of the facility with regional office functions, Form 2570 together with any radiographs taken in the case will be submitted to the regional office or facility with regional office functions having jurisdiction, for appropriate action.



(B) The chief dental officer may take appropriate action in accordance with (A) above for completion of adjunct dental [treatment] other than extractions and dentures, if considered necessary or advisable.

(C) Action will not be taken looking to the completion of treatment on an out-patient basis, authorized in a facility as domiciliary or auxiliary relief. [ ] (July 15, 1943.)

6230. BENEFICIARIES NOT TO BE PROMISED COMPLETION OF TREATMENT AFTER DISCHARGE. To obviate misunderstanding in cases where it is not possible to complete authorized dental [treatment] prior to discharge from the facility, particularly in cases of extraction and recommended replacement, medical and dental officers will refrain from making any statement to such beneficiaries which can be in any way construed as a promise of completion of dental [treatment] on an out-patient basis. (July 15, 1943.)

#### AUXILIARY DENTAL TREATMENT AS RELATED TO HOSPITAL DISCHARGE

6231. COMPLETION IF POSSIBLE BEFORE DISCHARGE; READMISSION IF NOT COMPLETED.— [(A) While patients receiving hospital treatment for a disease or injury not incurred nor aggravated by military or naval service can be supplied auxiliary dental treatment, such auxiliary treatment cannot be rendered in an out-patient status. Consequently, every effort will be made to complete and insert any artificial dentures authorized as auxiliary treatment before these patients are discharged from hospital.

(B) When a beneficiary comprehended by (A) has been furnished treatment in a Veterans Administration facility, or upon the authority of the Administration in a facility other than one under direct and exclusive jurisdiction of the Veterans Administration for a disorder not incurred in nor aggravated by military or naval service, and in the course of that treatment has had an extraction of teeth for which replacement is indicated, but the dentures either cannot be made at such hospital, or be finished before completion of hospital treatment, such beneficiary will be informed that, upon his application, he can be rehospitalized for the purpose of being furnished dentures. However, an application for readmission will not be accepted at the time of such discharge.

(C) The rehospitalization contemplated in (B) will usually be effectuated in the nearest facility under direct and exclusive jurisdiction of the Veterans Administration; and to such facility will be referred applications received, from such potentially entitled persons, at regional offices (except that in Philadelphia), or at facilities other than that nearest to the applicant's place of residence.

(D) No such rehospitalization for fitting of artificial dentures will be authorized, if the applicant has an uncleared offense against facility discipline, until the prescribed period of his exclusion from readmission has expired.

(E) Upon receipt of an application for readmission leading to supplying of artificial dentures, the chief dental officer will ascertain from the applicant at what facility his teeth had been extracted and, by correspondence with the chief dental officer thereof whether the teeth had actually been extracted, upon due authorization, as auxiliary dental treatment, and that replacement had not been made. If the information so developed shows eligibility of the applicant for artificial dentures, the chief dental officer will satisfy himself that the applicant's mouth is in such condition that dentures can be fitted. If there are other teeth to be extracted, or excessive bony structures preclude construction of a satisfactory denture, the applicant may be admitted for such services. If thereafter it is found impracticable to proceed with the fitting of dentures, the patient may be again discharged and instructed to apply for rehospitalization at such time as the chief dental officer sets for construction and fitting of dentures.



(F) When a denture has been fitted, the beneficiary will not be retained in the hospital for any extended period to ascertain if subsequent adjustments are necessary; a determination by the chief dental officer that the dentures fit satisfactorily and need no further adjustment should ordinarily be made within 24 to 48 hours. Any later adjustments which are judged needed - such as trimming of the periphery or adjusting the bite - cannot be authorized to be made by a designated dentist, but can be attended to at the facility clinic where the dentures were made, provided the beneficiary defrays the expense of his travel to and from that clinic.

(G) Rehospitalization will not be authorized for construction of new dentures to replace those lost or which have become unserviceable for any reason, or to repair broken dentures.

(H) Rehospitalization will apply to applicants who had teeth extracted in or were discharged from facilities prior to November 1, 1937, as well as those who were and are being dehospitalized after that date.

(I) Should an entitled beneficiary be hospitalized for a reason other than fitting of dentures, advantage will be taken of the opportunity to proceed with his dentures.

(J) Leave of absence may be granted directly after admission for the construction of dentures to beneficiaries who may desire it, particularly those residing in the immediate vicinity of the facility. This possibility will be explained to potential beneficiaries at the time information is requested as to the mode of travel desired, etc., and inquiry made as to whether they desire to avail themselves of this privilege. Possession of this information will materially facilitate allocation of colored beneficiaries to appropriate facilities. The Form 2593, Record of Hospitalization or Domiciliary Care, prepared at time of discharge of such patients will show "0" under the entry "actual number of days in hospital." And these patients will not be included under any items on Form 2601, Monthly Report of Veterans Administration Facilities; but, in the upper right corner of Form 2601 will be entered, opposite the legend "Number admitted for dentures and given leave of absence upon admission," the number concerned for the preceding month. Reporting for an impression, bite, try-in, etc., will not be considered to terminate a leave of absence. Transportation will be supplied these beneficiaries to cover their first trip to the facility and upon their formal discharge after completion of the dental service, but they will be required to defray the expense of any other intermediate visits to the facility.

(K) Upon completion of dentures for a beneficiary whose teeth had been extracted at another facility, a copy of the Form 2614p, Dental Record, showing the furnishing of the dentures, will be sent to such other facility, where it will be filed in the clinical records of the ex-patient, next to the Form 2614p showing the extractions. When the teeth had been extracted in a Federal hospital other than one under direct and exclusive jurisdiction of the Veterans Administration, the extra copy of Form 2614p will be placed in the beneficiary's C-file.] (July 15, 1943.)

6232. BENEFICIARY'S STATEMENT IN AUXILIARY DENTAL TREATMENT.--(A) Before any auxiliary dental [treatment is begun for a mentally competent beneficiary, he will be required to read and sign the following statement, or it will be read and explained to him:]



Facility \_\_\_\_\_

Date \_\_\_\_\_

As a beneficiary being furnished hospital treatment for a nonservice-connected disability, I understand that I am entitled, under existing law, to such dental [treatment] as may be considered as "auxiliary" to the treatment of the disease or injury for which I have been hospitalized, provided such dental [treatment] may be rendered as part of existing facilities of the hospital, and while I am a patient therein. I also understand that it may be impossible to complete the authorized auxiliary dental [treatment] before I am sufficiently well to leave the hospital. Should I be discharged from the hospital without having authorized dental treatment completed, I understand that I am not thereafter legally entitled to the completion of the dental treatment on an out-patient basis at the expense of the Veterans Administration. I also understand that any fillings, crowns, bridges, plates, etc., which may be furnished me while a patient in this hospital, and which after my discharge may require any adjustments, repairs, or replacement, will have to be attended to at my own expense, the Veterans Administration being without authority of law to furnish such service in these circumstances. I certify that I have carefully read the above, or that it has been read to me, that I fully understand it, and subscribe to the provisions thereof.

\_\_\_\_\_  
(Signature of patient)

Name \_\_\_\_\_ Register No. \_\_\_\_\_

(B) Should the beneficiary decline to sign this statement, or to accept auxiliary dental [treatment] under the conditions therein stipulated, no dental [treatment] of any kind will be rendered him, except emergency, and he will be discharged, "Unimproved, Auxiliary Dental [Treatment] Refused," provided he requires no further hospitalization for the basic disease or injury which led to his hospitalization. All signed statements will be securely stapled (use no ordinary detachable clips) to the patients' clinical record, dental, and will be disposed of in accordance with the provisions of R. & P. [6235.]

(C) The provisions of (A) and (B) hereof will not apply to incompetent beneficiaries, for whom any authorized [treatment] will be furnished without securing a statement that would have no validity by reason of mental irresponsibility. When no statement is secured by reason of incompetency of a patient, a statement to that effect will be indorsed on the back of Form 2614p. One copy of all Forms 2614p of patients for whom auxiliary dental [treatment] has been rendered must have attached a signed statement as required by this paragraph, or a statement showing the reason for its absence indorsed thereon. (July 15, 1943.)



## EMERGENCY DENTAL TREATMENT

6233. (A) Should a beneficiary being furnished [hospital treatment or domiciliary care report directly to a dental clinic with a condition requiring emergency relief, such relief will be promptly rendered, without reference of a member to his sick call or of a patient to his ward physician. Request for dental treatment other than emergency, will be handled in accordance with the provisions of R. & P. 6222.]

(B) Emergency [ ] relief of pain only may be rendered members on furlough, either voluntary or enforced, but no [dental service] whatsoever will be rendered a former member subsequent to his discharge from the facility.

(C) If there is a Form 2614p for a patient or member reporting for emergency [relief, on file in the dental clinic, the relief rendered will be recorded thereon. If no such form is of record, one will be partially executed, showing only the beneficiary's name, register number, C-number, if any, and ward or company on its face, and a record of the relief rendered on the back. If the beneficiary is a hospital patient Form 2614p will be sent to the clinical records file; and, if a member, it will be filed in his member's treatment file (see R. & P. 6109 (C)).] (July 15, 1943.)

## DENTAL FILES AND RECORDS

6234. (A) DENTAL FILES.—Chief dental officers in facilities will maintain these files: (1) Active treatment; [(2) abeyance (in two sections); (3) monthly reports; (4) prophylaxis (for neuropsychiatric facilities only); (5) Regulations and Procedure, Medical and Hospital Service; (6)] Administrator's Decisions, Service Letters, etc., concerning dental activities.

(1) Active Treatment—[In this, filed alphabetically, will be kept the Dental Clinical Records, Form 2614p, together with the Dental Record Chart and Oral Examination Blank, Form 2570,] and radiographs of beneficiaries actually under treatment.

(2) Abeyance—[ This file will be maintained in two sections In the first will be kept Forms 2614p and radiographs (mounted and inclosed in standard envelopes) of patients for whom dental treatment has been authorized but is deferred because of their present physical or mental condition. The second section will contain the Dental Clinical Records, Form 2614p, the Dental Record Chart and Oral Examination Blank, Form 2570, and radiographs of those beneficiaries for whom treatment has been prescribed, but has as yet not been begun. The Dental Clinical Records, Form 2614p, will be filed alphabetically in the first section, and by either date of prescription or according to urgency, in the second section. The charts in the second section will be so arranged that those having priority will be at the front, to be transferred to the active treatment file from time to time as circumstances permit beginning of treatment for additional patients. The chief dental officer will maintain a close follow-up on all Forms 2614p in the first section.]

(3) [Monthly Reports - In this will be kept the clinic copies of the Monthly Report of Dental Operators, Form 2587, Monthly Report of Dental Clinics, Form 2587a, and retained copies of all other reports prepared by the chief dental officer. All reports for each month will be filed together in a manila folder. Folders will be arranged by months with the latest filed in front. Copies of reports more than a year old will be reported as inactive records as provided in R. & P. 630-636, inclusive.

(4) Prophylaxis - This file, for neuropsychiatric facilities only, and consisting of 3 by 5 inch cards on which will be noted the name, register number and ward of every patient in the hospital, is to be used by the dental hygienist to check routine prophylaxis. Notations will be made on the card of the patient each time prophylactic care has been given him. Notation will also be made of patients who are edentulous and whether or not they are supplied with satisfactory artificial replacements.

A new card will be prepared for each patient reporting for dental examination, and the cards of patients who have died, been discharged or transferred will be destroyed without reference to the provisions of R. & P. 630-636, inclusive.

(5) Regulations and Procedure, Medical and Hospital - This file will be kept in a standard binder and will at all times be maintained current.

(6) Administrator's Decisions, Service Letters, etc.--This file will contain Decisions, Service Letters, All Stations Letters, etc., affecting dental activities.

(B) USE OF FILES FOR OUT-PATIENT CASES.--At facilities in which out-patient dental treatment is given, the same files, where applicable, will be used. (July 15, 1943.)

6235. DISPOSITION OF DENTAL RECORDS.--(A) Each day, when the daily census report (see R. & P. 6111) is received all Forms 2614p of beneficiaries who have been discharged or transferred or have died, will be removed from the files. These removed forms, together with those of beneficiaries whose treatment has been completed will be disposed of as follows: those related to hospital patients will be routed to the clinical clerk for filing in the clinical records, active or inactive, of the patients concerned; those related to domiciliary members will be filed in the member's treatment files. (See R. & P. 6109.)

(B) Dental radiographs will be routed to the X-ray laboratory for filing with other exposed films for the patient. Beneficiaries' statements obtained as required by R. & P. 6232, will be routed for filing in the clinical files of the patients concerned, attached to the Forms 2614p. (July 15, 1943.)

6236. DENTAL LABORATORY REQUISITION AND WORK RECORD.--This Form, 2804, is used to request services of a central dental laboratory. It is prepared in triplicate, an original and two copies. The original and one copy are sent to the central dental laboratory, and the second copy is retained. Upon completion of the prosthetic work at the central dental laboratory, the original is returned, with the piece-work cost and unit value of vitallium cases entered upon it, and is sent to the finance officer at the end of the month. The second copy, which had been retained at the station, is a work sheet. It will be held temporarily in a manila file pending fabrication of the desired appliance at the central dental laboratory. When that appliance has been received and satisfactorily fitted, this work sheet may be destroyed. (July 15, 1943.)

[6237. MAILING OF DENTAL PROSTHESES.--In accordance with the Postal Laws and Regulations, as amended May 17, 1943, packages containing dentures or other dental prostheses will be accepted for mailing, provided the label or address side of the package bears a printed or rubber-stamped impression, over the name of the sender, reading "Mailing not prohibited by section 607, P.L. and R. 1940". To effect compliance, field stations will procure a rubber stamp bearing, in block letters 3/16 inch high, the legend quoted, which will be stamped in red ink along the top of the franked mailing label, Form 3202.] (March 28, 1944.)





## NURSING

6240. [ORGANIZATION.--(A) The nursing organization of a hospital will consist of a chief nurse, head nurses, and nurses; and, if these are assigned to the station, of an assistant chief nurse, nursing assistants and volunteer nurses aides. Hospital attendants will be an auxiliary part of the nursing organization.

(B) In hospitals for general medical and surgical patients, with a standard bed capacity of 750 or more; in hospitals for tuberculous patients with a standard bed capacity of 850 or more; and in neuropsychiatric hospitals with a standard bed capacity of 1,000 or more, the organization will include an assistant chief nurse.

(C) For duties of a chief nurse, assistant chief nurse, head nurse, supervising night nurse, nurse and nursing assistant; and of head attendant (A), (B) and (C), and hospital attendants (A), and (B), see Outline of Duties and Responsibilities of Field Personnel.] (July 31, 1943.)

[6241 canceled July 31, 1943.]

## DIETETICS

6242. [ORGANIZATION.--(A) The dietetics organization of a hospital will be composed of a chief dietitian, an approved number of head dietitians and dietitians, and an assistant chief dietitian, if assigned to the station. Cooks, bakers, meat-cutters, head waiters and mess attendants will be auxiliary parts of the organization.

(B) An assistant chief dietitian may be assigned to a facility whose relative size and responsibilities of the dietetic service justify the appointment.

(C) For duties of a chief dietitian, head dietitian, dietitian, chief cook, head cook, cooks (A) and (B), assistant cook, senior baker, baker, meat-cutter, head waiter and mess attendant, see Outline of Duties and Responsibilities of Field Personnel.] (July 31, 1943.)

6243. TYPES OF FOOD SERVICE.--[(A) For patients and hospital personnel, the food service will be of two types - ward and dining room. Physicians will prescribe diet therapy for patients, and determine whether any individual patient will have ward or dining room service. In no instance will a patient be permitted to select his own diet. As an important factor in preventing prolonged invalidism, patients who are able and who do not have to be segregated from the group for medical reasons will be encouraged to take their meals in a central dining room. Where seating space is limited, ambulatory patients on special diets and those who are crippled may be served in the central dining room before or after the ambulatory regular diet ones. In the case of wheel chair patients, tables will be elevated sufficiently to permit comfort in eating. Clinical directors or chief medical officers will require physicians to check, monthly, as to the number of patients on their wards who are receiving special diets, and constant attention will be given to the economic necessity of providing special diets, or food items supplemental to regular menus, only when demanded by a patient's condition. Prescriptions for dietetic treatment, including between-meal nourishment, will be included in the ward physician's daily requisition to the chief dietitian (Form 2603, Consolidated Diet Sheet). This will show the number of patients on the ward, kind of diet for each, and the food supplies needed for the 24-hour



period. The chief dietitian, checking the diet orders, will forward to the supply officer a list of supplies to be issued from the subsistence stores.]

(B) Meal hours for wards and dining rooms will be decided by the manager and posted on bulletin boards of the facility.

[(C) Personnel entitled to subsistence will receive from the personnel office monthly subsistence pass Form 2540, 2541, or 2542, according to whether contract provides for 3, 2 or 1 meals daily. These cards will be punched or otherwise checked at the entrance to the dining room by a dietitian, head waiter, or other designated employee for the meals furnished; and upon expiration of the contract or separation from the service will be surrendered to the personnel office for cancelation except in an instance where an employee expresses a desire to retain his pass after maturity date. Under such circumstances, before retention by the employee, the expired pass will be stamped or marked canceled in the personnel office so that it would be obvious at a glance to a person checking employees into the dining room that the pass had been canceled. The used passes collected by the personnel office will be reported at the end of six months as inactive records.] (July 31, 1943.)

6244. FOOD SERVICE ON WARDS.--(A) The ward physicians will limit the food service on the wards to those patients whose condition will not permit of their going to dining rooms, or whose dietary requirements are such that service on wards is more practicable. Whenever station facilities and number of dietitians on duty permit, the chief dietitian will assume full responsibility for this type of service. Under other circumstances, the service of food on wards, prepared in accordance with the chief dietitian's menus, will be conducted by the ward nurses. The preparation of between-[meal] nourishment, such as albumenized fruit juices or gruels, will also be under the supervision of a dietitian. Trays will be served from one or more central diet kitchens under the supervision of a dietitian and conveyed to the wards in closed tray carriers, when feasible. The use of elevators, dumb-waiters or conveyors will facilitate this service. Every effort will be made to serve appetizing food and to have trays look attractive. Dishes will be heated or chilled in accordance with the food to be served, and all necessary measures taken to have food reach the patient in proper condition.

(B) Where isolation of wards or other conditions make central tray service impracticable, separate diet kitchens will be maintained on the wards. Food for ward patients will then be conveyed from the main kitchen to the various diet kitchens in the standard food carts, and will consist of the diets prescribed by the ward physicians. The food deliveries will be checked on arrival at ward diet kitchens, and any discrepancies in orders or deficiencies in delivery, preparation, or appearance of the meals will be reported to the chief dietitian. The trays will be set up in the ward diet kitchens and served from the food carts or from steam tables installed in the kitchens. The dietitian on duty will give close supervision to the serving of trays, and will check all weighed diets before their delivery to patients for whom they have been prescribed. The diet kitchens and food depositories will be kept locked when not in use. No patients or employees not actually occupied with duties in the diet kitchens, will be permitted in such kitchens.

(C) Wards having a number of ambulant patients who can not be sent to the main dining rooms, will be provided with separate dining rooms adjacent to the ward diet kitchens, where such patients will be served.



(D) [Whenever it is necessary, because of inability to assign a dietitian, the nurses will be responsible for food service from a ward diet kitchen. The nurse in charge of the ward will prepare the consolidated diet list, for signature of the ward physician and forwarding to the dietitian, early each morning. No food supplies in excess of 24-hours requirements will be ordered or kept on wards. Diets will be entered on the clinical records - total amount for 24 hours, liquid or semi-liquid, regular and special. Any food brought in by relatives or friends of patients will be turned over to the chief dietitian. Diet kitchens will be kept scrupulously clean and orderly, and locked when not in use. The nurse will note the temperature and variety of the food served her patients, its attractiveness, the prevailing food tastes of the patients, and the foods left over by them. Without expressing opinion to them, she will report to the chief dietitian any complaints of patients regarding the food. Surplus food in diet kitchens (except as provided in (F)) will be sent to the main kitchen, after each meal, for disposition. Bread may be held over for toasting. Nurses will supervise attendants' handling of food on tuberculosis wards or wards for other communicable diseases. Garbage receptacles are to be sterilized with live steam and kept covered. Food carts and utensils must be thoroughly clean. All plates are to be scraped before sterilization, and all dishes and utensils thoroughly sterilized. Clean towels will be used each time, and dish towels deposited in soiled linen containers.]

(E) Dietitians will daily visit wards to consult physicians and nurses regarding diets and, upon request by ward physicians will contact patients in reference to their diets. In planning diets, consideration will be given to the likes and dislikes of individual patients insofar as their desires do not conflict with their dietetic treatment as prescribed by ward physicians, or with the economical operation of dietetic activities.

(F) Surplus food left in diet kitchens after each meal will be returned to the main kitchen for disposition by the chief dietitian, except such food from wards of patients suffering from tuberculosis, syphilis and other communicable diseases. (July 31, 1943.)

6245. FOOD SERVICE IN DINING ROOMS.--This type of service will be maintained for all patients who are permitted to leave their wards for meals and for all personnel, members of welfare organizations, guests, and others who are authorized to be furnished meals on the station. Separate dining rooms will be maintained for patients and personnel. Provision will be made at each station for the service of a [night] meal to nurses, attendants and others assigned to night duty. All meals [for patients] will be inspected by the officer of the day and a dietitian. Every effort will be made to maintain a high standard of quiet, efficient service. Food left at the end of the meal in vegetable dishes or on platters (where family service is used), or in serving rooms, will be returned to the main kitchen for disposal. (July 31, 1943.)

[6246.] CLOTHING TO BE WORN BY PATIENTS IN GENERAL DINING ROOMS.--Ambulant patients in facilities primarily of the general medical or surgical type, who are clad in ward clothing (pajamas, bathrobe, slippers), may wear such clothing when attending general messes. Ambulant patients in facilities primarily of the tuberculous or neuropsychiatric types will be required to wear outer clothing when attending general messes. In neuropsychiatric facilities, clean overalls or sweaters may be worn in lieu of coats; and, in warm weather, coats may be discarded (uniformly) in



both tuberculosis and neuropsychiatric facilities. When coats are discarded, belts should be worn, rather than suspenders. Patients engaged in occupational therapy projects will be required to perform thorough ablutions and to discard soiled work clothing for clean clothes before appearing in the general mess. After meals, they will change to work clothes before resuming occupational therapy activities. (July 31, 1943.)

**[6247.] PREPARATION OF FOOD.**—(A) Food for patients and hospital personnel will be included on the chief dietitian's daily requisition upon the supply officer, and will include subsistence supplies necessary for a 24-hour period. Where the location and adequacy of refrigeration at the facility necessitates the issuing of perishable supplies to the chief dietitian in amounts in excess of 24-hour requirements, such supplies, as well as all daily issues of subsistence supplies to the dietetic department, will be checked for quality and quantity by the chief dietitian or a responsible employee of her service at the time of receipt from the supply officer. Suitable precautions will be taken to safeguard these supplies, and daily records of their utilization will be maintained by the chief dietitian on Form 2819.

(B) Food will be prepared by the chief cooks and other cooks, bakers, meat-cutters and mess attendants, as required, under supervision of the chief dietitian and her assistants. Left over foods on wards or in dining rooms will be inspected by a dietitian, who will instruct the chief cook concerning its disposal. Meals will be served promptly, but food will not be prepared too far in advance of the meal hour when this would impair its flavor and appetizing appearance. (July 31, 1943.)

**6248. [MENUS FOR PATIENTS AND PERSONNEL.**—(A) These will be planned by the chief dietitian or one of her assistants. The regular diet menu will be prepared weekly on Form 2836 and submitted to the chief medical officer and the manager for approval before service. Other routine diets, including light, soft and liquid, will be furnished as required. Special diets such as diabetic, nephritic, cardiac, etc., will be prepared in accordance with the physician's orders to meet individual needs. Dietitians will confer with ward physicians regarding such diets and through them will keep in touch with the progress of the patients. Copies of the daily routine and special diet menus on Form 2835, or an approved station form in lieu thereof will be distributed daily to ward serving centers, dining rooms, kitchens and other food preparation units, as indicated, for the guidance of personnel engaged in the preparation and service of food. A complete file of these menus should be maintained at the station and copies forwarded to central office only upon request. Copies of the weekly regular menu on Form 2836 will likewise be posted at the facility where required in connection with food preparation and service. At the end of each month one set of the regular diet menus will be forwarded to central office, with corrections in ink to indicate any changes or substitutions found necessary after approval of the menu by the station officials.]

(B) Personnel who are furnished meals at the facility, will be served from the same menu as that provided for regular diet patients. Special diets may not be furnished to personnel on duty status. When it is definitely determined by medical examination at the facility, that continued dietetic treatment is essential to the health of an individual employee, no special diet treatment will be furnished at the station; but information regarding the employee's condition should be forwarded to central office for consideration relative to a change of contract granting allowance for subsistence, in order that the employee may provide himself with a suitable diet away



from the station. In like manner, when an employee classified as a food handler may require a corrective diet, no such diet may be furnished at the station. Since it is required that subsistence be included in the employment contract of such an individual, it will be necessary for him to be transferred to other duties before central office can give consideration to a change of contract providing for subsistence away from the facility. [Employees living off the station and not having contracts for partial subsistence will not be permitted to partake of occasional meals at the facility except during their tour of duty when the location of the institution, transportation problems, or other unusual conditions, make it impracticable for them to obtain meals at their homes or at commercial eating places. Employees occupying housekeeping quarters at the station likewise will not be granted the privilege of occasional meals in the facility dining rooms unless exceptional circumstances prevail. When special conditions warrant the extension of guest meal privileges to facility employees whose contracts do not include subsistence, determination will be made by the manager in each case. Guest meals will be served in the facility dining rooms upon presentation of Guest Meal Card, Form 2684, and signing of the "Register of Guest Meals" by each guest.]

(C) Except when special diets are necessary, the following diets and types of food in general will be served to patients at Veterans Administration facilities:

(1) Liquid diet: to consist of strained fruit juices, strained soups, broth, beef tea, strained gruels, albumins, egg-nogs, milk, cream, malted milk, ice cream, ices, clear gelatin desserts, junket, cocoa, chocolate, tea, coffee.

(2) Soft diet: to consist of foods included in liquid diet, plus pureed vegetables; cooked fruits (without roughage); cooked cereals; potatoes (mashed, baked); macaroni or spaghetti (plain cooked); eggs (soft-cooked); cottage cheese; butter; white bread (day old); custards; milk puddings; gelatin desserts; sponge and angel food cake.

(3) Light diet: to consist of all foods included in liquid and soft diets, plus soups served on regular diet; broiled lamb chops and bacon; eggs; poultry; sweetbreads; fish; oysters (raw or in stew); brains; scraped beef; creamed or grated cheese; graham bread; potatoes (creamed or scalloped); young tender vegetables; prepared cereals; simple puddings and cakes.

(4) Regular diet - menus for regular diets will be planned on the basis of a [nutritionally adequate] diet and will include all the dietary essentials in proteins, carbohydrates and fats, correct amounts of fluid and residue, mineral salts and vitamins. The regular diet will contain from [2500 - 3500 calories, with from 10 to 15 percent of the total calories in protein, and amounts of other specific nutrients in accordance with current knowledge of dietary essentials to insure good nutrition and protection of all body tissues for the moderately active man weighing approximately 70 kilograms. It] will be regarded as the foundation upon which other hospital diets are to be built and will be planned with the special diet requirements of patients clearly in mind. This diet will furnish a variety of foodstuffs, with special attention to a liberal supply of milk, eggs, good quality of meats, fresh fruits and vegetables. The sedentary life of the group to be served will affect the selection of food. Easily digested and laxative foods will predominate. Poultry, beef, and lamb will be served more often than veal and pork; simple desserts such as ice cream, stewed fruits, or light puddings, with greater frequency than rich cakes and pastries. (July 31, 1943.)



6249. PATIENTS DETAILED TO DIETETIC SERVICE.--When neuropsychiatric patients are detailed, for prescribed occupational therapy, to the dietetic service, they will be under careful supervision of an attendant who will be responsible for their conduct and protection from injury. [All patients who assist in the serving of food, setting up of tables and distribution of chinaware, and those detailed to the dining rooms at meal time will wear the usual white coats designated for employees. To distinguish patients from employees, coats worn by patients will be marked by a color-fast delft blue twill arm band, two inches in width, placed on the left sleeve, midway between elbow and shoulder, such bands to be fabricated at the station. Patients assigned to vegetable preparation rooms, dishwashing and janitorial work in the dietetic section will wear the standard white apron over the usual occupational therapy clothing. Where the nature of the work is such as to require additional protection, water-proof duck aprons may be worn in lieu of the standard white apron. Patients will not be permitted to wear coats and aprons outside the dietetic section. Sufficient coats and aprons will be provided to assure a clean and neat appearance at all times. A minimum of three coats and five aprons will be provided each patient assigned. This prescribed clothing will be worn at all times during the handling or serving of food, china or silverware.] (July 31, 1943.)

#### PREVENTION OF FOOD WASTE

6250. (A) REMAINING FOODS ON WARDS.--Care will be exercised to prevent excessive supplies of foods being sent to wards. The tray-service will be carefully observed and supervised. Trays will be made as attractive as possible, to stimulate appetite. It is advisable to make a small first serving, followed, if the patient requests, by a second serving, to obviate waste and prevent revulsion suggested by an overloaded tray.

(B) REMAINING FOODS IN DINING ROOMS.--The same care and judgment regarding size of portions will be exercised in the dining room service as in the ward service. Food left in serving dishes or steam tables will be put in suitable containers in refrigerators for further utilization. Bread and butter will receive special attention as regards both method of serving and disposition at the end of the meal hour. Equipment for slicing bread and for cutting butter into squares for individual service will be provided at each facility. Appropriate storage for bread in boxes or cabinets will be provided. Leftover bread and pieces not suitable for serving will be utilized to advantage in the main kitchen. Likewise, butter left on tables or on common butter dishes will be saved for cooking and seasoning. The dietitians will study the general likes and dislikes of patients for the various articles of the menu. Dishes which are usually rejected by a large number of patients should not appear on menus. All economic measures possible will be practiced, not with the object of depriving patients and personnel of a liberal, high standard dietary, but in a spirit of proper control of waste.

(C) DISPOSITION OF FOOD WASTE.--Plate-waste from diet kitchens and dining rooms will be sent to the central garbage storage section in closed containers for that purpose, after each meal. Similarly, food waste in main kitchen, serving and preparation rooms, will be kept in closed receptacles and sent to the central storage section at frequent intervals. All food-waste will be examined regularly by the dietitians, the chief cook and the head waiter, who will be responsible for keeping this



waste at a minimum. Garbage will be carefully weighed and separate weights of the edible and inedible waste recorded daily. After weighing garbage it will be refrigerated or otherwise maintained under acceptable sanitary standards until removed for sale, hog feed or other disposition. The records of separate weighings from dining rooms and diet kitchens will be posted weekly for the information of the personnel on duty. Edible waste will include such scraps of food left on plates as meat, bread, vegetables, etc., that might normally have been eaten by the individual; while inedible waste will include items not considered satisfactory for human consumption, such as bones, coffee grounds, egg shells, roughage resulting from vegetable and fruit preparation, etc. At facilities raising hogs the inedible waste will be further separated so that all roughage from fruits and vegetables suitable for hog feed may be used for that purpose, and satisfactory disposition made of the remainder by incineration or by other means. In addition, at facilities where garbage is utilized for feeding the swine on the station farm or disposed of to parties outside of the facility for hog feed, no uncooked fresh or cured and smoked pork scraps, including bones, will be included in the station garbage, but such waste products will be thoroughly cooked and then added to the garbage in order to eliminate the possibility of spreading hog cholera and trichinosis through garbage feeding of infected pork products. Accurate records of edible and inedible waste, including per capita amounts of each, will be included in the Quarterly Report of Hospital Dietetic Department, Form 2653, forwarded to central office at the end of each quarter. See left-over food from tuberculosis wards. (July 31, 1943.)

6251. SUBSISTENCE SUPPLIES FOR PERSONNEL IN WOMEN'S QUARTERS.--Milk, cream, bread, butter, eggs, bacon, cereals, coffee, tea, sugar, salt, pepper, limited amounts of fruit, crackers, jelly or jam, may be issued, in the discretion of the manager, for use of night nurses, or for employees sick in women's quarters who are employed on a full subsistence status but are unable to go to personnel dining rooms. [When the employees in women's quarters who accept these supplies in lieu of regular meals are physically unable to assume responsibility for the preparation and service thereof, a facility employee assigned to work in the quarters will perform such duties. If such employee is not available, an appropriate employee will be detailed to the quarters to perform these tasks, or meals will be furnished from the employees' mess.] Full record of such subsistence issues will be maintained, and requisitions therefor will be prepared on Form 2598. This privileged service will not be construed as a precedent for deviation from regulations governing the personnel employed on quarters and full subsistence basis, residing in women's non-housekeeping quarters. The issue of rations for the use of those employees during leave of absence from the facility is not authorized. Subsistence allowance contemplates the furnishing of three meals a day, and subsistence supplies issued as provided herein will be in lieu of and not in addition to the corresponding regular meals available in the personnel dining room. (November 14, 1944.)

6252. SUBSISTENCE PASSES.--Form 2540, Employee Full Subsistence Pass, Form 2541, Employee Partial Subsistence Pass - 1 meal, and Form 2542, Employee Partial Subsistence Pass - 2 meals, will be used in checking meals served employees on subsistence status of employment. These passes are to be filled in to show the name of the employee (with designation if desired), date of issuance, etc., and signed by the authorizing officer upon issuance to the employees, according to their individual employment contracts.

Furnishing meals to Veterans Administration employees other than those under contract of employment; to welfare workers, guests of employees; concessionaires; relatives or individuals visiting beneficiaries; and to volunteer entertainers; and charges to be made therefor: see R. & P. 955-958. (July 31, 1943.)



## FOOD POISONING: ITS PREVENTION AND INVESTIGATION

6253. (A) PREVENTION.--(1) Continuous vigilance will be exercised to insure cleanliness and freedom from communicable disease of employees handling foods and in the storage, preparation, cooking and serving of foods, to prevent their contamination.

(2) Food-handlers, including employees, patients assigned to dietetic activities as an occupational therapy project, and persons employed by station concessionaires, will be given the prescribed general physical examination and special examinations for food-handlers before they enter upon such duties, and at periodic intervals while they are so occupied. No such individual will be assigned to food-handling or be permitted to continue such duties if found to be suffering from or be a carrier of communicable systemic or skin disease, especially pulmonary tuberculosis, venereal infections and intestinal disorders. A positive Wassermann reaction of the blood, confirmed, will be sufficient cause for exclusion of the individual from such duties, even in the absence of clinical evidence of syphilis. An employee or patient found to have a communicable condition may be assigned to some other occupation not calling for contact with raw or cooked foods. Absolute cleanliness of the person and clothing of employees and patients assigned to food-handling duties will be exacted. The employees will wear the white washable suits prescribed in R. & P. 6008, 6009 and 6013, and patients the white coats and aprons provided in R. & P. 6249. Frequent bathing of such individuals, and particular care of their hands and finger nails will be insisted upon by their superiors. Those with cuts on the hands, skin lesions, gastro-intestinal disturbances, or eye, nose and throat infections will be referred to the physician attending ill or injured personnel.

(3) Raw foods will be stored to protect them against spoilage or contamination by rodents and insects. Subsistence storerooms will be ventilated, and their windows and doors screened. Rat-proofing and water-proofing of floors and walls will be assured. No insect powders, disinfectants or cleansing supplies will be stored where they might come in contact with or be mistaken for canned or bottled foods. Patients assigned to dietetic activities as an occupational therapy project in a neuropsychiatric hospital will not be permitted access to subsistence storerooms, except when authorized by the chief medical officer or clinical director. Food-handlers will be instructed in the detection of deteriorated or infected foods, and should become familiarized with norms of quality, appearance, odor and texture of foods in bulk or sealed containers. They will be cautioned to report to their superior, without delay, any food whose condition they think questionable. A raw food should be fresh in appearance, free from stale or offensive odors, or from discolorations or mould. Swollen or leaking cans are readily recognized.

(4) Refrigerators will be scrupulously clean, and their interior temperatures will be frequently checked to be certain of the maintenance of required cold levels. Employees will be cautioned to keep open refrigerator doors only so long as is necessary to deposit or withdraw contents. To secure rapid chilling, it is advisable to divide foods into separate portions, rather than to place large amounts in a single container in a refrigerator.

(5) Special precautions will be taken to insure the prompt use of perishable supplies, as seafood, liver, sweetbreads and poultry. Carcass meat will not be kept out of the refrigerator any longer than is necessary for cutting chops, roasts, etc. Pork, because of its limited keeping-qualities, requires especial care; bacterial growth rapidly produces slime on its surface; it must be chilled quickly and

thoroughly and kept at low temperature until it is to be cooked. Meat for hamburger steak, stews, etc., will be ground or chopped the day it is to be served, and this rule will apply to the cutting of pork chops, veal outlets and liver. When poultry has been drawn and cleaned, it will promptly be put in a refrigerator, for chilling. Frozen fowl will be thawed quickly. Frozen fish will be thawed in ice or cold water just before it is to be cleaned or sliced for cooking. When whole cooked ham or tongue are not to be served immediately after cooking, they should be spread out in suitable containers for quick cooling before placing in refrigerators. During the cooling process, precautions will be taken to prevent contamination. If these items are to be served the day following cooking, they must be cooked early enough in the day to be cooled and refrigerated before the food department is closed. Under no circumstances will such foods as boiled ham or tongue be left at room temperature overnight to cool. Special attention should be given to the necessity for thorough cooking of all cuts of pork, not only to make them palatable, but to insure destruction of the trichina parasite. When dressing is to be served with poultry, the poultry should not be stuffed with the bread mixture, but the latter should be mixed and baked separately just prior to the serving period. Likewise, the ingredients for meat loaf, hamburgers, and other ground meat products should be mixed just before cooking. Any such cooked products left over at the end of the meal should not be held longer than the following day before use. Likewise, creamed and starchy foods, custards, or other egg mixtures, and any cooked foods returned from steam tables or dining rooms, must be used not later than the next day. Although cold cooked fowl or ham left over in the main kitchen at the end of a meal and refrigerated promptly, may be kept longer than the second day before use with reasonable safety, it is extremely important to use up promptly any sliced chicken or ham that has been handled by several employees in the process of serving.

(6) For foods that cannot be reheated after handling, such as jellied meat loaf or filled pastries and cakes, especial sanitary precautions are to be taken. The time between preparation and serving will be as short as possible, and the product will be kept covered in that interval; it will also be refrigerated if this is possible without spoiling its texture. These precautions apply also to fresh and canned foods, served singly or in combination, that cannot be recooked after handling. Thus, fresh fruits, melons, berries, and vegetables to be served raw should be thoroughly washed, chilled and served promptly. In the case of canned foods to be served cold, any dust should be removed from the outside of the cans before they are placed in the refrigerator to chill the contents. If the canned items are to be combined with other foods in salads or desserts, the contents should be removed from the cans and the process of preparation accomplished as quickly as possible. They will be chilled again before serving. All salad ingredients coming in direct contact with the hands during preparation, particularly fowl or veal to be boned and diced, will be cooled thoroughly before handling; chopped, ground or sliced meats, custards or other soft mixtures will be placed in shallow pans and immediately chilled, to obtain low temperatures throughout the mass. Frequent stirring, particularly in the case of cooked ice cream mixes, is advisable to prevent warmth in the center of the mixture that would provide for growth of bacteria. Freshly cooked foods when refrigerated should be placed in separate containers from like item left over from a previous meal.

(6253 Continued.)



In stacking trays of food in refrigerators, care should be exercised to provide air space between the trays. Because of the rapidity with which bacteria will grow in such a favorable medium as warm food, it has been determined that under ordinary circumstances, food should not be held at room temperature in excess of four hours following preparation. Exceptions to this rule will necessitate careful refrigeration.

(7) Study of reports of outbreaks of bacillary dysentery has indicated a need for special emphasis on the efficient operation of mechanical dishwashing units. Although such machines are constructed to provide for satisfactory sterilization of dishes, it was found that faulty operation could result in dishes leaving the machine with more bacteria than before the washing process. To insure maximum efficiency in dishwashing, these precautions are necessary:

(a) Dishes must be thoroughly scraped before washing and washed as quickly as possible after soiling.

(b) Dishes and utensils must be properly placed in machines. They will not be crowded together. Bowls and glasses will be placed on edge, to prevent an accumulation of water.

(c) An adequate amount of soap or other detergent will be used in the wash water, and a temperature from 110° to 120° Fahrenheit maintained during the washing process, to avoid cooking food particles on dishes. If a cold spray is used first, the temperature of the soapy wash water may be higher.

(d) Dishes and utensils will be rinsed at a temperature of 180° Fahrenheit. A sufficient amount of fresh water will be used so that there will be a frequent change of soapy wash water.

(e) Clean dishes will be handled as little as possible after coming from the machine. The personal cleanliness of the workers and their clothing are important factors in the final goal of insuring clean dishes.

(8) Where cafeteria service is in effect, clean plates or dishes will be used for second servings. With table service, whether family or individual plate style, care will be exercised to prevent common spoon or ladle from touching the plate or used dish. With plate service, the plates should go directly from the waiter to the individual served.

(B) INVESTIGATION.--(1) This will be intensively pursued immediately an epidemic of food poisoning becomes evident. The first steps will be to impound the food, secure specimens of vomitus and feces from affected persons, and to conduct a systematic survey to determine what foods were eaten, not only by persons made ill, but by persons not affected. The medical director will be informed by radiogram or telegram upon the appearance of any such outbreak; and the director of national homes will similarly be informed if the food poisoning epidemic occurred in a mess for domiciled members.

(2) When an outbreak of food poisoning cannot be controlled, or its origin established, through locally conducted investigation, the manager may ask that a pathologist be sent to his station from a facility allocated for this purpose. The facilities are, to this end, divided into twelve groups; and one, of two or more pathologists, assigned to certain hospitals in each such group, will proceed (upon travel order and transportation supplied by the manager of the station where he is regularly on duty) to that other facility where his manager has been requested to send him to take charge of a food poisoning epidemic. Usually, that pathologist will be asked for who can travel to the concerned station in the shortest time, even if the travel distance be greater than from another allocated facility.

(3) Field stations are allocated as follows for this purpose:

GROUP 1.

Togus, Maine  
White River Junction, Vt.  
Bedford, Mass.  
Northampton, Mass.  
Newington, Conn.  
Rutland Heights, Mass.  
Castle Point, N. Y.  
Northport, L. I., N. Y.  
Sunmount, N. Y.  
Bronx, N. Y.  
Lyons, N. J.

Pathologists in the facilities at the Bronx,  
Newington and Northampton.

GROUP 2.

Brecksville, Ohio  
Dayton, Ohio  
Chillicothe, Ohio  
Pittsburgh, Pa.  
Bath, N. Y.  
Batavia, N. Y.  
Canandaigua, N. Y.  
Huntington, W. Va.  
Lexington, Ky.

Pathologists in the facilities at Pittsburgh  
and Dayton.

GROUP 3.

Washington, D. C.  
Roanoke, Va.  
Kecoughtan, Va.  
Perry Point, Md.  
Fort Howard, Md.  
Coatesville, Pa.

Pathologist in the facility at  
Washington, D. C.

GROUP 4.

Dearborn, Mich.  
Fort Custer, Mich.  
Wood, Wis.  
Hines, Ill.  
Mendota, Wis.  
Dwight, Ill.  
Downey, Ill.  
Indianapolis, Ind.  
Marion, Ind.  
Danville, Ill.

Pathologists in the facilities at Hines and  
Indianapolis.

(6253 Continued.)



GROUP 5.

Mountain Home, Tenn.  
Oteen, N. C.  
Fayetteville, N. C.  
Tuscaloosa, Ala.  
Columbia, S. C.  
Augusta, Ga.  
Atlanta, Ga.  
Lake City, Fla.  
Bay Pines, Fla.  
Tuskegee, Ala.  
Montgomery, Ala.

Pathologists in the facilities at Oteen,  
Atlanta and Columbia.

GROUP 6.

Outwood, Ky.  
Murfreesboro, Tenn.  
North Little Rock, Ark.  
Memphis, Tenn.  
Biloxi, Miss.  
Alexandria, La.  
Gulfport, Miss.

Pathologists in the facilities at  
Memphis and Biloxi.

GROUP 7.

Jefferson Barracks, Mo.  
Marion, Ill.  
Wadsworth, Kansas  
Excelsior Springs, Mo.  
Wichita, Kansas  
Fort Lyon, Colorado

Pathologists in the facilities at  
Wadsworth and Jefferson Barracks.

GROUP 8.

Minneapolis, Minn.  
Fargo, N. Dak.  
Hot Springs, S. Dak.  
St. Cloud, Minn.  
Des Moines, Iowa  
Knoxville, Iowa  
Lincoln, Neb.  
Cheyenne, Wyo.  
Sheridan, Wyo.

Pathologists in the facilities at  
Minneapolis and Des Moines.

GROUP 9.

Dallas, Texas  
Legion, Texas  
Waco, Texas  
Amarillo, Texas  
Fayetteville, Ark.  
Muskogee, Okla.

Pathologists in the facilities at Muskogee,  
Fayetteville and Amarillo.

#### GROUP 10.

Albuquerque, N. Mex.

Fort Bayard, N. Mex.

Whipple, Ariz.

Tucson, Ariz.

Pathologists in the facilities at Whipple  
and Fort Bayard.

#### GROUP 11.

Portland, Ore.

Walla Walla, Wash.

Roseburg, Ore.

American Lake, Wash.

Fort Harrison, Mont.

Boise, Idaho

Pathologists in the facilities at Walla Walla,  
Boise and Fort Harrison.

#### GROUP 12.

San Francisco, Calif.

Livermore, Calif.

Palo Alto, Calif.

Reno, Nev.

Salt Lake City, Utah

Los Angeles, Calif.

San Fernando, Calif.

Pathologists in the facilities at Los Angeles  
and Livermore.

(4) Any instructions by telephone, telegram or radio that the expected pathologist may give pending his arrival will be carefully observed. Preliminary collection of data, specimens of food, excreta, etc., as provided in (1) will also have had appropriate attention at the station, pending his appearance. Upon arrival, the pathologist will take full charge of the situation, and will be given full cooperation by the manager and staff. The pathologist's report in full will be submitted to the medical director, with his comment and recommendations. If he desires additional assistance, including experienced, trained laboratory technicians, supplies and equipment, above the resources available at the station, he will make telegraphic request therefor upon the medical director.

(5) The organism principally incriminated in food poisoning is the staphylococcus (aureus and albus). Less often responsible are the salmonella (paratyphoid) group, and the clostridium botulinum (producing botulism). The streptococcus and bacillus proteus have also been reported as etiologic agents.

(6) Symptoms of poisoning from staphylococcus toxin appear usually in 2 - 4 hours; from salmonella in over 12 hours; and from clostridium botulinum in 24 - 36 hours. These respective usual periods of incubation will guide the investigators as to the probable meal involved; and the identification of the causative article of food in that meal will begin with the securing, if possible, of left-over portions of all such articles. These will be collected, packed in ice, and delivered at once to the clinical laboratory of the station; as will specimens of vomitus and feces of affected patients, which will be collected in sterile containers, then closed and labeled with the full names of the affected persons. Bacteriologic examinations of these foods and specimens will be begun without delay. Laboratorians (6253 Continued.)



will prepare smears of the foods and use gram stains, to obtain an impression of the preponderant organisms present. If botulism be suspected, the toxin will be sought by inoculation of laboratory animals - mice, guinea pigs or rabbits; and the suspected food will be cultured for spores, especially if the food had been prepared by boiling. When death of an affected person has occurred, a note will be securely attached to his bed tag, reading "Do not embalm until further notice," so that specimens for bacteriologic examination can be had of the blood, intestines, liver and spleen.

(7) Careful inquiry will be made, coincidently with the collection of food article and excreta, as to what items of food served in the suspected meal, had been eaten and had not been eaten, both by affected persons and by those who had escaped poisoning. Significant clues can be discovered by this eliminative survey which may simplify the collection of food items by focusing suspicion on some one or more articles. In general food poisoning by the staphylococcus or salmonella bacilli, freshly-cooked or warmed-over foods, minced meats, or pastry are the first to be suspected, despite the likelihood that such articles may appear normal in taste, odor, appearance and texture. Preserved foods are rarely incriminated in general food poisoning, whereas they are the first to be suspected in botulism. Meat products, such as ham and sausage, must also be considered in botulism, with which spoilage of food, and peculiarities of taste and odor, are often associated.

(8) A bacteriologic and epidemiologic search for human carriers, particularly in food-handling employees, is a part of the investigation of food-poisoning epidemics.] (July 31, 1943.)

## PHYSICAL THERAPY; OCCUPATIONAL THERAPY

6255. [ORGANIZATION.--(A) Reconstruction activities, comprehending physical therapy, physical exercises, occupational therapy and recreational therapy, will be directed, whenever possible, by a full-time physician, designated as reconstruction officer, and functioning under general supervision of the chief medical officer or clinical director.

(B) When the size of the facility does not justify the full-time services of a reconstruction officer, a part-time physical therapist (physician) may head the physical therapy and the physical exercise organization, and a part-time occupational therapist (physician) may head the occupational therapy and recreational therapy organizations; or, if the services of a full or part-time physical therapist or/and occupational therapist are not obtainable or not necessitated, authority may be requested from the medical director to assign a physician of the staff, most qualified, to these positions.

(C) For detailed duties of a reconstruction officer, see "Outline of Duties and Responsibilities of Field Personnel." (August 6, 1943.)

### PHYSICAL THERAPY

[6256. (A) DEFINITION OF.--Physical therapy or physical medicine is the treatment of disease or injury by physical agents, such as light, heat, cold, water, electricity, mechanical devices, and remedial exercises.

(B) PRESCRIPTION CF.--Ward physicians will prescribe the physical therapy (type, intervals between treatments, total number of treatments) for their patients and will refer them, with those prescriptions, to the physical therapist (physician) who will direct and supervise the rendering of the prescribed treatment by the technicians. The physical therapist is authorized to vary the treatment in correspondence with the progress made by the patient, but will notify the ward physician accordingly. These physicians will work in concert; in differences of opinion, that of the physical therapist will prevail.

(C) REPORTS OF - In reporting physical therapy there will be used

Form 2614m, Physical Therapy, Clinical Records. See R. & P. 6102 (P) for details of execution.

Form 2611, Daily Progress Report Card.

Form 2612, Monthly Report of Physical Therapy.] (August 6, 1943.)

### OCCUPATIONAL THERAPY

[6257. DEFINITION OF.--(A) Occupational therapy will include any occupation, mental or physical, which is prescribed and directed to promote recovery from disease or injury, and to aid in the hospital or extra-mural adjustment of patients.

(B) PRESCRIPTION OF - Ward physicians will ordinarily prescribe the type and desired period of continuance of occupational therapy. But where a reconstruction officer, as such, is assigned, or another qualified physician has been given the duties of a reconstruction officer, the chief medical officer or clinical director, as his judgment suggests, may require either that chiefs of services or ward physicians will confer with the reconstruction officer or other physician discharging his duties,



to settle upon a program of occupational therapy for patients concerned; or that the responsibility for all such prescriptions will rest with the reconstruction officer or the other physician discharging his duties, to whom all patients concerned will be referred with a full statement of diagnosis and symptoms.

(C) REPORTS OF - In reporting occupational therapy there will be used Form 2614-1, Occupational Therapy, Clinical Records. See R. & P. 6102 (O) for details of execution.

Form 2634, Monthly Report of Occupational Therapy.

Form 2588, Material Issue Slip and Record of Article Receipt.

Form 2589, Appraisers' List.

(D) In addition to these regular reports, the following statements (no standardized form) are to be submitted to central office:

(1) A statement of the annual production totals in the occupational therapy making of pajamas, mattress-covers and cook aprons. This report will show the amount and value of each item; the amount and values of material and supplies used; the amount and values of unused materials; the number and sizes of items made; the number of patients employed each day; the total number of individual patients occupied during the period; the hours per day of patients occupied; the total hours occupied during month or year; the number of employees assigned each day; the disposition made of the items fabricated; and the amount of waste material and how used.

(2) A statement on plain paper, each month, listing the items of repairs and articles fabricated for Government use, showing the approximate cost of material used in each, and the approximate commercial value.

(3) A statement on plain paper, each month, showing the value of services rendered by patients for whom occupational therapy was prescribed, based upon the salaries of personnel who are not required as a result of the services performed by these patients.】 (August 6, 1943.)

6258. STANDARDS; SUPPLIES.--【(A) The medical director will determine the standards of physical therapy and occupational therapy equipment and supplies in field stations.

(B) No installation of physical therapy or occupational therapy equipment will be made, nor requisitions for supplies for such activities will be placed, until authority is given by the medical director for the operation of such activities at the station concerned.

(C) Physical therapy and occupational therapy equipment and supplies will be furnished and requisitioned in accordance with Regulations and Procedure, Supply Service.

(D) Finished articles will be disposed of as promptly as possible. See R. & P. R-6083 et seq. relative to disposition of fabricated articles.

(E) In facilities other than those under direct and exclusive jurisdiction of the Veterans Administration, prescriptions for physical therapy and occupational therapy will be written by authorized physicians of the staffs of such hospitals; and the personnel, supplies and equipment to conduct such activities will be provided by such other facilities, under the terms of contracts for treatment and care of Veterans Administration beneficiaries.】 (August 6, 1943.)

6259. 【DUTIES OF PERSONNEL.--(A) For duties of chief physical therapy technician (formerly chief aide, physiotherapy) and chief aide, occupational therapy, see "Outline of Duties and Responsibilities of Field Personnel." A chief physical therapy



technician and chief occupational therapy aide will be responsible, under the general supervision of the chief medical officer or clinical director, for the efficient conduct of the required instruction courses for junior technicians and junior aides; and, in neuropsychiatric stations, for hospital attendants. A head or staff technician or aide will be designated by her or him to serve as acting chief, when she or he is absent from duty.

(B) Since physical therapy technicians and occupational therapy aides have had fundamentally different training and experience their duties are not interchangeable and they will be assigned to the position only for which they are qualified. During hours of duty, occupational therapy aides will not act as instructors to any persons other than patients for whom such instruction has been prescribed, as provided. Children of employees will not be taught by such personnel during hours of duty.] (August 6, 1943.)

**[6260.] OCCUPATIONAL THERAPY FOR TUBERCULOUS PATIENTS.**—Except when special permission is given by the medical director for some other activity, occupational therapy for tuberculous patients will be confined to the following occupations: crafts, including brass and copper; celluloid; leather; modeling; pottery; reed and cane; textiles. Requests for assignment to an occupational project other than one herein listed will be made only when, because of specific conditions, such other requested occupation is considered as of particular value; and such requests will be accompanied by information that the facility is adequately equipped to render the service within its current budgetary authority. (August 6, 1943.)

**[6261.] OCCUPATIONAL THERAPY FOR NEUROPSYCHIATRIC PATIENTS.**—(A) Occupational therapy for neuropsychiatric patients will be confined to the occupations enumerated in this paragraph except when special permission is obtained from central office for some occupation not listed herein: for psychoneurotics, crafts, including brass and copper; celluloid; leather; modeling and pottery; reed and cane; textiles; commercial art; music; agriculture and allied activities, such as animal husbandry, gardening, poultry raising, bee culture; printing; woodworking; shoe repairing; cement and metal work; for psychotics, agriculture and allied activities; hospital maintenance; brush making, broom making; mattress making; shoe repairing; tailoring (repairing only); woodworking; cement and metal work; music; printing; crafts, including brass and copper; leather; reed and cane; textiles.

(B) Emphasis will be placed on out-of-door occupations of a masculine type, when there is no contraindication. Supervised occupations about the station, such as care of lawns, drives, and quarters; work in the laundry, bakery, kitchen, power plant; doing station painting and repair work, will often furnish the best form of occupational therapy. It will be kept in mind, however, that the first objective of occupational therapy is the welfare of the patient and that any benefits accruing to the facility are secondary thereto. Manual labor will not be prescribed for psychotics as a routine matter, but occupations will be given which will meet the therapeutic indications, and at the same time, so far as practicable, enable the patient to fit into the maintenance program of the facility. The safety of the patient and other patients and employees must have due consideration in assigning him to an occupational therapy activity. Other than in exceptional cases, arts and crafts should be prescribed for neuropsychiatric patients only for habit-forming or kindergarten purposes. After such patients have made improvement and adjustment, they can be occupied at trade or agricultural projects, for facility maintenance. [See R. & P. 6185 for prohibition of



personal services by these patients for employees and concessionaires, and prohibition of entrance of these patients into employees' quarters, except as provided.] (August 6, 1943.)

[6262.] OCCUPATIONAL THERAPY FOR GENERAL MEDICAL OR SURGICAL PATIENTS.—Occupational therapy may be prescribed for only such general medical or surgical patients as will require prolonged hospitalization, or for those surgical and especially orthopedic cases which require certain occupations to preserve or restore function. Occupational therapy may also be prescribed for blind members receiving domiciliary care when considered advantageous. In facilities primarily for general and surgical patients where there are tuberculous or neuropsychiatric patients, occupational therapy for the latter classes of patients will accord with the types of occupations authorized for tuberculous and neuropsychiatric patients. [ ] (August 6, 1943.)

[6263. PROTECTION OF PATIENTS IN OCCUPATIONAL THERAPY PROJECTS.—(A) Due supervision of patients, particularly the neuropsychiatric, engaged in occupational therapy assignments, is imperative; not only to direct performance and to judge its adequacy, as well as to note mental and physical reactions to the projects, but also to provide protection against injury to themselves and others, especially when the patients are occupied in workshops, or are assigned to the utilities or dietetics activities of the station.

(B) Even when the immediate supervision of patients is the responsibility of other than personnel engaged in medical activities, (as when the assignment is to farming projects), general supervision by the medical division will be required. The minimum of such general supervision will call for one visit in the forenoon and one in the afternoon, to the occupied patients, by the reconstruction officer or by occupational therapy personnel designated by him. In addition to this general supervision, an occupational therapy attendant or hospital attendant will be present with each group of ten or more patients, on closed wards, who are engaged in occupational assignments.

(C) Neuropsychiatric patients can be assigned to a station laundry provided that the joint supervision specified in (B), that is, immediate supervision by laundry employees and general supervision by occupational therapy personnel (including attendants), is maintained. The exit doors in laundries will not be locked. The superintendent of the laundry will be instructed in writing to assure himself that interlocks on all machines are tested daily; such tests to be made while machines are in full operation.

(D) See R. & P. 6253 (A)(3) as to permitted entry of psychotic patients, assigned to dietetic activities, to subsistence storerooms.

(E) All machines used in workshops or in farm operations will be adequately equipped with safety devices, whenever at all practicable; guards must be attached over saws, knives, belting, motors and other moving parts. Machines will preferably be installed back to back or with backs against the wall, so that patients cannot pass between or behind them and so become endangered by belts, flywheels, etc. Lock switches, in addition to wall switches should be provided for motor-driven equipment. An individual checkout system for all tools used by neuropsychiatric patients will be in force, and such tools will not be kept in bench drawers.

(F) No neuropsychiatric patient who is not assigned to occupational therapy in a workshop will be permitted entry to such shop; nor will a psychotic patient assigned to the workshop be permitted to work alone in the shop. The workshop will be locked when the aide, occupational therapy, or other employee in charge, is leaving the shop.



(G) Injury to a patient through use of tools or machinery while engaged in occupational therapy will be reported on Form 2633, Report of Assaults, Accidents, Injuries, etc. It will be made clear whether the injury occurred during the course of a properly prescribed and supervised assignment, or whether injured patient had disregarded instructions and was attempting some unauthorized activity.

(H) A patient who is assigned to occupational therapy projects requiring protective clothing as specified, will be supplied such protective clothing at Government expense, irrespective of whether he has funds to his credit. The limitations or issue outlined under Regulations and Procedure, paragraph 9074 (A) will be rigidly complied with. Such clothing will not be issued to individual beneficiaries but to wards, and will be accounted for in the proper manner as station property.] (August 6, 1943.)

[6264. APPRAISAL OF BY-PRODUCTS OF OCCUPATIONAL THERAPY.—(A) A list of the items fabricated will be prepared in duplicate by the aide in charge of occupational therapy on Form 2589, Appraisers' List, using one serial number for each article, or one serial number for all similar items in any one project. The total number of similar articles will be noted. This list will be submitted to the board of appraisers, appointed in accordance with R. & P. R-6087, on or about the fifteenth and last day of each month; or at more frequent intervals if in the opinion of the manager circumstances may require. Items fabricated by the maker for his own use or the use of his family and not to be resold at a higher price, and shoe repairs for patients with funds or for employees, as the case may be, will be included. The occupational therapy personnel will enter on the Appraisers' List the serial number of each item or article or of the combination of similar items, and the proposed disposal. The board of appraisers will determine the valuation of each item or article, and the Appraisers' List will then be completed in duplicate as to the appraisal value, by the aide in charge. Signed by the board of appraisers, this list in duplicate will be retained in the station files until the report of audit is made by the finance officer, and forwarded to central office; whereupon the original of the Appraisers' List will be forwarded with that audit, addressed to the medical and hospital service. For articles forwarded to central office as proposed models, an appraisal will be made at the facility where those articles had been made. As of June 30 of each fiscal year, all by-products remaining on hand as of that date will be brought forward to a new appraisal list, dated July 1. All articles brought forward will carry the original serial number. The old Appraisers' List will be marked to show each article as having been transferred to a new Appraisers' List, and will then be closed.

(B) Form 2588, Material Issue Slip and Record of Article Receipt, showing the disposal of each by-product and repaired article will be kept in the files of the station. If the article is salvaged, this receipt will be executed and signed by the aide; if the article is sold to the patient, it will be signed by the patient; if sold otherwise, it will be signed by the purchaser; if taken over for Government use, either as a newly made by-product or repaired equipment, or if taken over by the Government as surplus, it will be signed by the supply officer. In lieu of the signature of the supply officer, a copy of Debit Voucher, Form 138, from the supply officer, properly completed, may be accepted and attached to Form 2588.

(C) In cases of articles forwarded to central office as samples or models, the original and one copy of Material Issue Slip and Record of Article Receipt, Form 2588, will be forwarded to central office with the article, and a third copy retained in



the files of the occupational therapy service at the facility. After the article has served the purpose for which it was forwarded to central office, it will be reappraised, if necessary, by a central board of appraisers and disposed of in accordance with instructions. A carbon copy of the Material Issue Slip and Record of Article Receipt will then be forwarded to the station from which the article was originally shipped, and the original of this receipt will be kept in central office, showing the appropriate disposal of the article.

(D) Collections of money due to the United States from the sale of by-products will be disposed of as provided in instructions regarding deposit of collections, recoveries, etc.] (August 6, 1943.)

[6265.] FABRICATION OF CLOTH POPPIES.—(A) The production of poppies will be included among the forms of approved occupational therapy. It may be prescribed; where indicated, but will not be substituted for more valuable established forms of occupational therapy. Managers of facilities in which this is considered a desirable form of occupational therapy, will cooperate with representatives of recognized ex-service and allied organizations in the production of poppies assembled from material furnished by these organizations, with the understanding that no expenditures for supplies will be chargeable against the Government. The money received for the manufacture of these poppies will accrue to the patients engaged in this work, and the procedure covering the distribution of these funds will be approved by the manager and handled by the person in charge of occupational therapy at each station. A detailed record of this activity will be kept, showing the number of poppies made, the names of patients engaged, and the remuneration each receives for the work.

[(B) The preparation of Form 2614-1, Occupational Therapy, Clinical Records, for patients assigned to poppy making or to ward service detail, or for patients for whom no other type of occupational therapy is prescribed, may be omitted, provided that a notation is made on that Form 2614-1, "Poppy Making" or "Ward Service Assignment," as the fact is.] (August 6, 1943.)

[6266 and 6267 Canceled August 6, 1943.]

[GROUP THERAPY - See R. & P. 6184, Occupation for Psychotic Patients, for the contribution of occupational therapy activities to the program of group therapy. A statement will be forwarded at the end of each year, showing the average number of patients participating monthly in group therapy independently of occupational therapy; the number included in group therapy in addition to occupational therapy; the extent of group therapy; and the apparent results obtained.] (August 6, 1943.)

## LIBRARIES

6268. [ORGANIZATION.— (A) Hospital libraries, to consist of a general library for patients and a medical library for the staff, will be included in the manager's general administration, but chief medical officers and clinical directors are responsible for library activities as assigned by managers. Personnel assignments for libraries will be made by central office. Library hours will be set by chief medical officers or clinical directors, and will be such as best meet the needs and do not interfere with the treatment and care of patients.

(B) For duties of chief librarian, librarian and assistant librarian, see Outline of Duties and Responsibilities of Field Personnel. At facilities where patients are assigned to assist in routine library duties, they will be under immediate direction of the chief librarian or of her assistant. Where such patients are not so assigned, the librarian will have the assistance of a janitor or attendant, to transport the loaded book truck between the library and wards, or on inclines, steps, etc., and to assist in other necessary manual labor. When a book truck cannot advantageously be used, the janitor or attendant will carry books and magazines in baskets or other containers.

(C) A hospital library will be so located that it will be quiet, well lighted and central, easily reached by patients in wheel-chairs or on crutches. It will be accessible to the wards, so that the library personnel may conveniently visit bed patients with the book truck. In facilities for neuropsychiatric patients the location of the library in the recreation building may be desirable, to permit space for groups of locked-ward patients to visit the library, accompanied by an attendant. When, in those hospitals, there is a ward for tuberculous psychotic patients, a small library for them will be built up by supplemental purchases of certain new and popular books, by transferring duplicate copies from the general library, or by adding gift copies which have been approved by central office.

(D) Librarians will visit wards twice a week, with the book cart if possible, and it is desirable that the reception ward be visited daily. They will consult with the chief medical officer or clinical director in carrying out the program of bibliotherapy, and in arranging the time of visits to wards, so as not to interfere with the ward routine.

(E) The medical library will be housed separately from the general library, in a separate room not open to patients, but a part of or near the chief librarian's office. When the conditions of construction are such that this arrangement is not possible, the medical director will be informed, and authority requested to house the medical library in a location suggested by the manager. When the medical library is so located that the chief librarian cannot give it direct supervision, the responsibility for property (books, journals, etc.) will be assumed by the chief medical officer or clinical director, but the chief librarian will continue to discharge her other duties as related to the medical library. Patients will not be permitted access to or use of any medical books and journals.

(F) When circumstances necessitate that a hospital librarian assume the duties of a recreational aide in conjunction with library duties, her official status will remain unchanged.] (September 20, 1943.)

6269. [LIBRARY REQUISITIONS.—(A) The number of standard and current volumes, and the number of magazine and newspaper subscriptions for hospital libraries will be determined by the medical director.



(B) (1) The cost of reading material for beneficiaries is chargeable to central office allotment, and requisitions therefor will not bear authorization and procurement numbers. Requisitions for books, magazines and newspapers will be submitted separately. No funds are available for the purchase of recreational reading material for employees, but they may be granted library privileges provided service to patients is not interfered with.

(2) Requisitions for books will be submitted to central office as often as necessary to keep reading matter current, and will not be restricted to a quarterly submittal. The only exception will be that, toward the end of each fiscal year, requisitions for books will not be given consideration if received after April 15, unless accompanied by an explanation of the emergency. Requisitions covering titles "Recent books for hospital use", central office, will be separately submitted and not combined with miscellaneous titles. Requisition for Supplies, Form 3211, will be used and the necessary information entered in the following order, leaving the first column blank: Author (full name or initials of first and middle names), title of book, publisher, quantity desired and price. Names of book dealers will not be substituted for those of actual publishers. Retail prices will be given. Double space will be left between typewritten entries. Lists of gift books will be submitted double-spaced, with names of authors arranged alphabetically, and title and copyright date given on each entry, in accordance with R. & P. 8602.

(3) Requisitions for magazine subscriptions will be submitted annually to reach central office before August 1. Title will be selected from central office approved lists and be entered alphabetically on the requisition. If, because of local interest or other good reason, it is judged advisable to include titles not appearing on an approved list, such titles will be entered alphabetically with others, and a statement of the necessity made.

(4) A limited number of newspaper subscriptions, according to local needs, may be approved for patients. Newspaper subscriptions will be requisitioned separately and placed to begin with the calendar year; such requisitions must reach central office prior to August 1. Usually not more than one subscription for each newspaper will be approved for a hospital library.

(C) MEDICAL BOOKS AND JOURNALS.--(1) It is expected that all stations will requisition a sufficient number of medical and related technical books and journals to meet actual requirements and to keep the medical library material current. Librarians will keep in touch with reviews of medical publications as much as possible, and consult with chief medical officers and clinical directors in preparing these requisitions.

(2) Medical books represented as essential to the needs of stations will be given consideration, but the medical director may make such substitution of titles as he judges advisable.

(3) New editions of medical books will be approved as replacements for old editions only when, in the opinion of the medical director, sufficient advance has been made in the subject to warrant replacing editions already in use. Requisition for Supplies, Form 3211, will be used in proposing such replacement, and an explanation will accompany it.

(4) The cost of medical and related technical books and journals is chargeable to a central office fund and requisitions therefor will be submitted unencumbered. Such books and journals will be requisitioned separately. It is imperative that all requisitions for yearly subscriptions to journals reach central office before August 1.



(5) Medical books deemed obsolete but in serviceable condition may, at the discretion of the manager, be returned to the supply officer for disposition as surplus property, accompanied by a statement from the responsible employee setting forth the reason the books have become surplus. The author, title, publisher, edition, date of publication and serviceability of such book or books will be indicated.

(D) Since advance payment is required for all subscriptions, it is highly important that note be taken of failure to receive issues of a medical journal, or of a magazine or newspaper. Librarians will use periodical record cards, making entries in the appropriate columns, with occasional note of the specific date the publication reaches the library, as well as of the actual issue received. The date of receipt so entered will serve to determine the time the next issue may be expected to arrive. An automatic check will be maintained (the date fixed by the librarian for this review of all record cards will be dependent upon the frequency of the periodical - whether daily, weekly, monthly, bimonthly or quarterly), and at the end of each month any shortages, together with all pertinent facts in each case, will be reported to the supply officer, who will contact the contractor relative thereto. If satisfactory results are not obtained, the supply officer will report the facts to the supply service, central office, for corrective action.] (September 20, 1943.)

6270. [POSTAL FRANK FOR LIBRARY BOOKS.--Books loaned to a facility by a neighboring library or the Army Medical Library, may be returned under frank; but it is unlawful to inclose franks to libraries for use in mailing books to the facility. Books from the Army Medical Library are sent out franked from Washington, D. C.] (September 20, 1943.)

6271. [COLLECTION AND DISTRIBUTION OF UNDELIVERABLE MAGAZINES, ETC.--Postal laws and regulations authorize postmasters, to give to municipal officials, upon request, undeliverable magazines and newspapers, falling within the term "waste paper", for which no sale can be effected by the postmasters. Managers of Veterans Administration facilities will request a share in such periodicals, subject to the condition cited, and further provided that no franking privilege is authorized, and managers must provide postage if such reading matter is to be sent to facilities by mail. Arrangements may be effectuated by managers, with the larger neighboring post offices, whereby deliveries of such magazines and newspapers can be made to chauffeurs of station vehicles at convenient periods when such vehicles will be making trips upon some other regular duty. Such reading matter when received at facilities will be inspected by librarians, who will destroy that part, if any, which they consider not adapted for patients.] (September 20, 1943.)

[6272. LIBRARY ACTIVITIES IN GROUP THERAPY.--Subject to the principles outlined in R. & P. 6184, Occupation of Psychotic Patients, library activities will be a part of the coordinated program of group therapy in hospitals for mentally ill patients.] (September 20, 1943.)

## RECREATION

6273. [ORGANIZATION.--(A) Recreation for patients is included in the manager's general administration of facilities, but chief medical officers and clinical directors are responsible for recreational activities as assigned by managers. All such activities will be directed by a recreational aide, responsible to the manager, but under the general supervision of the chief medical officer or clinical director.



(B) For duties of recreational aide, see Outline of Duties and Responsibilities of Field Personnel. A recreational aide or chief librarian-recreational aide will be responsible for contacting bedridden and helpless patients, upon notification by ward nurses, and arranging for purchase of postage stamps, procurement of money orders, and mailing of registered matter for such patients as request these personal services. Bonding of these employees for the handling and custody of patients' funds for the said purposes will not be required. As an alternate or assistant to the recreational aide or chief librarian-recreational aide when their duties preclude performance of these personal services, an employee of some other unit of the hospital will be designated, with the understanding that the recreational aide or chief librarian-recreational aide, respectively, will be responsible for the direct supervision of the personal services aforesaid by such designated employee. The prohibition, by R. & P. 9684, of the indorsement of checks drawn payable to patients must have due regard; an employee can assist a patient in the negotiation of checks only to the extent of identifying the patient. But lacking means for cashing checks afforded by concessionaires, or the Red Cross, or at times by postmasters, patients may deposit funds at the station for safe-keeping with privilege of withdrawal, under R. & P. 4766. Ordinarily, such withdrawals are not to exceed \$5.00 a day, but in emergency the manager of the facility may, in writing, approve and authorize a larger withdrawal.

(C) The kinds and scope of recreational activities will be governed by consideration of what is sound therapeutically for the types of patients concerned. All recreational programs for patients will be submitted to the chief medical officer or clinical director for approval and reference by him, indicating approval or disapproval, to the manager, for final decision.

(D) Recreational activities at the expense of the Government will be confined strictly to those arranged on the facility reservation.

(E) Candy and other confectionery, tobacco and tobacco products, and telephone service will not be furnished at Government expense to beneficiaries in facilities, except that tobacco and cigarettes, postage stamps, etc., may be furnished as provided to members and patients who are eligible therefor.

(F) Buses or other means of transportation of beneficiaries to entertainments outside of a facility, or of entertainers to and from a facility (so far as such entertainment is possible under current rules governing use of vehicles for pleasure), will not be hired without prior authority of central office. Entertainers, as defined, besides being furnished surplus or prepared meals in lieu of payment for services, can be supplied transportation in a station vehicle to and from the facility; but the policy of limiting use of such vehicles during the national emergency will curtail the arrangements for outside entertainment.] (September 20, 1943.)

6274. [ENTERTAINMENTS.--No admission charge will be collected for any recreational entertainment at a facility, except as provided for baseball games at facilities primarily for domiciliary members, see R. & P. 7860 (B). Admission to motion picture entertainments will be governed by these conditions:

(A) The seating of all beneficiaries who desire to attend and whose attendance is not disapproved by their ward physicians, will be paramount.

(B) The facility personnel necessary as attendants for such beneficiaries will next be accommodated.



(C) If, after the beneficiaries and their attending personnel have been accommodated, seats remain, these will be supplied the following in the order specified: Visiting relatives of patients; employees of the facility and their families, residing on the reservation; guests of personnel, only when such guests and personnel are actually residing on the reservation; representatives of recognized ex-service organizations visiting the facility on business connected with their organizations.

(D) Persons who were formerly beneficiaries at the facility but are no longer receiving treatment or care, or are not employed at the facility; and relatives or guests of such persons, will not be admitted.

(E) Former employees of the facility and their relatives or guests will not be admitted.

(F) Employees and their families or guests, when not residing on the reservation of a facility, will not be admitted.] (September 20, 1943.)

6275. [PARTICIPATION OF OTHER ORGANIZATIONS IN HOLIDAY ENTERTAINMENTS.--(A) If outside organizations express a desire to participate in the holiday entertainments, they may be permitted to do so, with the understanding in all cases that the entertainment will be exclusively under the management, control and supervision of the manager of the facility.

(B) See procedure governing the furnishing of names of hospitalized beneficiaries to organizations desiring to make Christmas gifts.] (September 20, 1943.)

6276. [FACILITY AUDITORIUMS AND RECREATION HALLS.--(A) The use of auditoriums or recreation halls at facilities is primarily for meetings to provide entertainment and recreation for beneficiaries. Such auditoriums and halls may be used for meetings of medical societies and administrative officials of the Veterans Administration to consider the medical treatment and care of beneficiaries. Upon special approval of the manager, the uses may include other purposes which relate to the welfare of beneficiaries and employees, provided that meetings for such purposes be so scheduled as not to interfere with the primary purposes. The manager of the facility will acquaint himself with the nature and character of entertainments or meetings to be held in auditoriums and recreation halls, and must assure himself that the property will not be damaged and that the class of entertainments or meetings will reflect credit upon the Veterans Administration. As a basis for scheduling uses in accordance with these principles, the purposes of meetings will be considered in the following order of preference:

(1) Meetings for the entertainment or recreation of beneficiaries.

(2) Meetings of groups of employees having to do with the conduct of the affairs of the facility; meetings of persons not employees, when in the judgment of the manager this is in the interest of official business.

(3) Meetings of employees.

(B) The use of auditoriums or recreation halls will not be permitted for State or district conventions or meetings of community posts of ex-service organizations, but may be permitted for facility posts of such organizations whose membership is composed principally of beneficiaries or employees of the facility; and for the instruction of members of ex-service organizations relative to benefits administered by the Veterans Administration, particularly when a Veterans Administration employee is present in an advisory capacity. This last mentioned privilege will be granted subject to discretion of the manager of the facility, and with a view to "the welfare of beneficiaries and employees", referred to in (A).



(C) Auditoriums or recreation halls may be used for meetings of employees: (1) For entertainments, for which no admission fee is charged, and (2) for assemblies of societies, associations or federations organized for the orderly consideration and promotion of the interests and welfare of employees, whose officials present credentials to show the character of the organization is such as to reflect a reasonable expectancy of permanency, and that the objects are not contrary to the laws or policies of the United States Government, and are pursued by methods not disruptive of the administration of the facility.

(D) Auditoriums or recreation halls may be used for the funeral ceremonies of beneficiaries who, before their deaths in facilities, made such request, provided the auditoriums or recreation halls are not in use or had not been engaged for use for some other authorized purpose at the time of such funeral ceremonies.

(E) Political meetings at facilities will not be permitted.

(F) Money collections will not be made during religious ceremonies at a facility.] (September 20, 1943.)

**[6277.] CENSORING OF MOTION PICTURES; MOTION PICTURES ON MEDICAL SUBJECTS.--**

(A) Films depicting crime, drunkenness, bootlegging, or those which tend to engender racial or class prejudice, those which are frankly sexual in their appeal, or which would have a depressing effect upon the patients, will not be shown. In neuropsychiatric facilities the exhibition of pictures depicting imprisonment, insanity, or those which are too intensely dramatic will be avoided. Films to be exhibited in such facilities should be largely comedy films. In many instances the film which it is contemplated showing may be viewed prior to its display in the facility, and when this is not practicable usually a synopsis may be obtained for review. It is hereby directed that the manager, either in person or by representative, closely censor films which are to be shown, in order to prevent the exhibition of pictures which may have deleterious effect upon the patients.

(B) There are on the market a number of sound motion pictures on scientific medical subjects which might be of mutual benefit to the members of staff of Veterans Administration facilities and the local, city or county medical societies, as well as advantageous in maintaining a friendly relationship with such societies. It will frequently happen that the local secretaries of various medical associations in the vicinity of Veterans Administration facilities will desire to secure these films for presentation before their societies. In such instances it will be mutually beneficial to all concerned to have a joint meeting in the station auditorium for presentation of the films. Managers are therefore authorized to utilize auditoriums for this purpose at a time which will not interfere with beneficiaries' programs. (September 20, 1943.)

**[6278.] BANKING FOR PATIENTS.--**Representatives of reputable financial institutions may be permitted by managers, upon request of beneficiaries, to contact competent beneficiaries, with the distinct understanding that permission for such contacts is not to be construed by beneficiaries as a guaranty by the facility of the integrity or financial soundness of the institutions, and that any transactions with such institutions will be on the beneficiary's responsibility. Canvassing for sale of securities in facilities is strictly prohibited. The provisions of this paragraph will be placed on bulletin boards in facilities. (September 20, 1943.)

**[6279.] DRIVING OF AUTOMOBILES BY BENEFICIARIES.--**The driving of automobiles by patients or members will be forbidden, except as to those whose condition, in the judgment of the chief medical officer or clinical director, is such as will not be detrimentally affected thereby, and will not, also, make their driving unsafe for



the public. A statement of this policy will be placed upon bulletin boards of facilities. Managers of regional offices and of facilities with regional office activities will advise heads of other Government hospitals or civil contract hospitals of their territories that it is desired this policy shall extend to beneficiaries of the Veterans Administration receiving treatment in such other hospitals. (September 20, 1943.)

**[6280. FACILITY FORMS AND PUBLICATIONS.—(A)** Mimeographing, duplicating, overprinting or printing will not be carried on as an occupational therapy project unless authorized by the medical director. When it is proposed to introduce a new (not previously approved) form for station use, three copies thereof, with an explanation of need for the form, will be forwarded to the chief, regulations and procedure division, central office. The same procedure will be observed when a field station proposes modification of a previously authorized form in use. (See also R. & P. 760-773.)

**(B)** No field station will undertake a printing or mimeographing project, as occupational therapy, upon request of any other field station, unless such request is accompanied by a copy of letter from the medical director, authorizing the reference of the project to another field station. Similarly, no printing or mimeographing will be undertaken by any field station of the Veterans Administration upon request of any other Federal agency, until authorization therefor is requested and obtained from the medical director.

**(C)** Station publications will be subject to the provisions of (A) and any such publication that is being issued under such conditions will not be mailed under frank, except as to copies forwarded to central office or exchanged with other facilities of the Veterans Administration.

**(D)** Advertisements in publications issued at facilities are not permitted, as constituting violation of the regulations of the Joint Committee on Printing of the Congress. (See also R. & P. 740.)

**(E)** Yearbooks for its field stations are not approved by the Veterans Administration, and managers, when solicited in regard to the publication of yearbooks will inform commercial publishers and individuals accordingly. (September 20, 1943.)

**6281. [STATION FUND.—**The maintenance of any fund, variously known as "hospital," "contingency," "special," "slop," or "slush," for the purpose of defraying expenses of entertainment, decoration, printing, etc., not authorized as legitimate Government expenditures, is prohibited at Veterans Administration facilities. For authorized funds, see R. & P. 4769.] (September 20, 1943.)

#### LETTER AND PARCEL MAIL AND EXPRESS PACKAGES FOR BENEFICIARIES

**6284. [(A) MENTALLY COMPETENT BENEFICIARIES.—(1)** See R. & P. 430 for correspondence for central office or regional offices with beneficiaries, and R. & P. 443 as to dispatching mail to and from field stations. Except where there is a postal sub-station at the facility, and mail is distributed therefrom by an employee of the Post Office Department directly to ambulant beneficiaries, managers will appoint one or more trustworthy employees who will be responsible for the prompt and safe delivery of mail.

**(2)** Ambulant patients will be required to call at a desk, centrally placed, for delivery of mail, but delivery on wards will be made to bedfast patients. If, for any reason, mail cannot be delivered or forwarded, it will be returned to the



post office from which it was received, with a brief explanation of the reason for non-delivery. Where there is a post office at the facility, beneficiaries who are being discharged, or transferred to another facility, or are going on furlough or leave of absence will be instructed to leave a forwarding address with the postmaster, by executing the post office form for that purpose. If there is no postal sub-station in the facility, a book will be maintained for entries of such forwarding addresses. See R. & P. 4482, Use of Form 572, Claimant's Request for Change of Address, and R. & P. 4483, Disposition of Checks Received by Facilities.

(3) Envelope mail addressed to a patient, including letters enclosing checks, will be delivered unopened to the addressee unless, in the opinion of the manager, the physical or mental condition of a patient requires that his mail be opened before delivery to him. This authority must be carefully exercised, with only the welfare of the patient in mind. Such receipts as are required on post office cards or forms for delivery of registered or insured mail will be obtained, and a register showing the post office registry number of each piece of registered mail sent and received will be maintained as provided in R. & P. 517.

(4) Parcel post and express packages will be opened by addressees in the presence of an employee, and confiscation will be made of any contraband article discovered therein. Parcel post or express packages which are being sent out by patients will be inspected and cleared before leaving the facility. Any Government property found to be contained will be removed.

(B) MENTALLY INCOMPETENT PATIENTS.--(1) Mail and express packages for psychotic patients who are determined to be mentally competent will be handled as provided in (A).

(2) All letters for incompetent patients will be opened by managers or their designates, to ascertain the nature of the contents thereof. Letters of a business nature related to the patient's estate will be forwarded to the fiduciary, if any. Ordinary, friendly correspondence will be delivered to the patient unless thought detrimental to his welfare, in which case the letters will be forwarded to the fiduciary of the person, if any. If there is no such fiduciary, the manager or his designate may either deliver the correspondence to the patient, if he thinks that advisable, or may ask the advice of the chief attorney as to the propriety of forwarding it to the nearest relative.

(3) Mail or express packages for those patients will be opened by their ward physicians, who will decide whether the contents will be delivered to the patients or stored for them. Packages containing food will be sent to the chief dietitian for disposition.

(4) Letters written by mentally incompetent patients will be delivered by nurses or hospital attendants to ward physicians, for censoring. This censorship will be intelligent and liberal, not arbitrary or unnecessarily stringent. The object is to protect the public. Such letters, when addressed to the manager, or to central office, or other stations of the Veterans Administration, a State hospital commission or the judge of the court of commitment, will be forwarded to the manager of the facility by the ward physician concerned, without being opened. The manager will censor the mail addressed to central office or any other organizational unit of the Veterans Administration, and will destroy what is incoherent or obscene. Letters which are coherent, even if abusive (without obscenity) or which contain charges against any of the facility personnel, will be forwarded, with a letter of comment, to the medical director, in a manila envelope, marked "Patients' Mail". The mail



room will deliver such envelopes to the medical director, unopened. The manager will forward patients' mail addressed to judges of courts or State hospital commissions, unopened, with a letter of transmittal. When a ward physician, in reading a patient's letter addressed to a person or official other than specified in the foregoing, finds it unfit for mailing because of incoherence or obscenity, he may retain it in his possession for delivery to the guardian, if the guardian's visits to the patient are frequent; or he may deliver it to the manager, who, in an explanatory letter, will request the guardian to state whether he wishes such letters sent to him, by express collect, or desires that they be destroyed at the facility. Action will be taken in accordance with the guardian's instructions. If the incompetent patient has no guardian, the ward physician will destroy such letters. Letters which have been deposited in boxes in the facility which were not installed by the Post Office Department are not United States mail, and may be collected and disposed of as herein provided. (September 20, 1943.)

[6285 and 6286 canceled January 25, 1944.]

#### PREVENTION OF INTRODUCTION OF PROHIBITED ARTICLES

6287. [PROHIBITED ARTICLES.--(A) Beneficiaries accepted for hospitalization will not be permitted to bring into a facility, whether upon their person or in luggage, firearms or other weapons, ammunition, intoxicating liquors, narcotics, medicines for self-administration, or any other articles which, in the judgment of the manager, should be prohibited introduction.] (January 25, 1944.)

[6288. INSTRUCTIONS TO ACCOMPANY TRAVEL ORDER.--(A) With the Notice to Report for Hospitalization or Domiciliary Care, Form 2511 series or 2515, which is sent to a mentally competent applicant, authorizing his travel for hospital treatment (see R. & P. 6070), will be inclosed a station-prepared slip instructing him as to what personal clothing and toilet articles he should bring. He may be told to pack at least 4 pairs of socks, 3 suits of underwear, 3 shirts, a razor, razor blades, shaving cream or soap, shaving brush, hair comb, hairbrush, toothbrush, toothpaste or toothpowder; that the suit, shoes, hat and overcoat that he wears upon incoming travel should suffice for wear when he leaves the hospital; that a bathrobe, pajamas and slippers may be brought if he wishes, though these articles can be supplied at the hospital; and that he must not bring any of the prohibited articles named in 6287.

(B) If the accepted applicant be mentally incompetent, the foregoing slip of directions will be sent his guardian or nearest relative, with these modifications: Mention will not be made of razors or razor blades; and it will be stated that when the patient is later found to need other articles, the guardian or nearest relative will be notified to forward them.] (January 25, 1944.)

[6289. INSPECTION OF LUGGAGE UPON ADMISSION.--(A) When an ambulant, mentally competent beneficiary is admitted, he will be informed as to the prohibition against introduction of certain articles, which will be named; and will be asked to sign a station-prepared slip, reading: "As a condition of my admission to this facility I consent to the confiscation, and disposition as seen fit, of any articles prohibited introduction which are now or may hereafter be found in my possession." His luggage will then be opened and inspected in his presence, and he will be asked whether he has any such forbidden articles upon his person. If there is reason to doubt his denial, he will be asked to submit to search of his person. If he refuses inspection of his luggage, or search of his person (if proposed), he will be informed that his admission to the facility must be refused, and he will be required to depart with his luggage.



(B) If a patient be emergently ill upon admission, an inspection of his personal clothing and luggage will be made by the admitting officer and an attendant; and his signature to the consent slip will later be obtained when his condition permits. The same procedure will be applied in admission of an unconscious patient.

(C) The luggage and person of a mentally incompetent patient will be inspected without execution of the consent slip.

(D) Consent slips, provided in (A), will be placed in the correspondence files related to the beneficiaries. When a beneficiary declines to sign that slip, the notation "Signature Refused" will be made across the face of the slip, with the initials of the admitting officer. (January 25, 1944.)

6290. [CONFISCATION AND DISPOSITION OF PROHIBITED ARTICLES.--(A) Any prohibited article found on the person or in the luggage of a beneficiary at or after his admission will be impounded. Cartridges or shells so discovered will be exploded promptly, or otherwise safely and surely destroyed; except that if it be established that the beneficiary is by occupation a hunter of predatory animals or wild game, the manager may direct that such ammunition be safely stored, for delivery to the beneficiary upon his discharge, or in accordance with his instructions should he die in the facility. This exception will be in force for duration of the present emergency. Ammunition or weapons brought in by beneficiaries who are in active service, or discharged from military service, will be disposed of in accordance with instructions requested of the commanding officer of the area service command. The same action will be taken if Army equipment, which should not be in their possession, is brought in by beneficiaries. Other articles confiscated will be placed in a safe or vault at the facility, in the exclusive custody of the supply officer or his designate, in accordance with existing instructions, pending disposition. If the State laws forbid the possession of intoxicants, the local State officer having jurisdiction will be requested to instruct as to disposition of confiscated liquor, and his instructions will be followed. If the State laws do not forbid possession of intoxicating liquors, such of these as are confiscated will be stored in the custody of the supply officer until the owners are discharged, whereupon the impounded liquor will be returned to them; provided that if any such owner dies in the facility, the intoxicating liquor taken from him will be destroyed. Narcotics confiscated will be reported to the Federal officer having jurisdiction, whose instructions as to disposition will be followed. The disposition of weapons (other than Army property, as provided) will be in accordance with existing instructions. Guardians or, if no guardians, the nearest relatives of mentally incompetent beneficiaries from whom medicines for self-treatment have been taken will be requested to state promptly whether they wish the impounded article destroyed at the facility, or shipped express, collect. If no reply is received one month after such notice, destruction of the article will be proceeded with. Medicines for self-treatment confiscated from mentally competent patients, will be held until their discharge, when such medicines will be returned to such patients, with advice as to inadvisability of self-treatment. If such patients die during hospitalization, these medicines will be destroyed.

(B) If, after his admission, it is discovered that a mentally competent patient had concealed any prohibited article at time of admission, or has received or brought in any such article, the procedure under (A) will be observed; and, in addition, charges will be preferred for hearing by a hospital board of discipline.

(C) Ward physicians will make periodic inspections at irregular intervals, of lockers and bedding on wards. If such inspections disclose possession of prohibited articles, the provisions of (B) will be followed.

(D) A notice will be posted on bulletin boards of facilities, prohibiting the possession by beneficiaries of intoxicants, narcotics, firearms or other weapons, ammunition, and medicines for self-treatment.】 (January 25, 1944.)





## EFFECTS OF MENTALLY INCOMPETENT PATIENTS

6292. [PROCEDURE UPON ADMISSION.--(A) Mentally incompetent patients will be completely stripped upon hospital admission and carefully examined, not only to record cuts, bruises or other injuries, as well as the general physical characteristics of the patients, but to ascertain if they (or their clothing) are verminous, or the patients are showing any evidence of communicable disease. After being bathed, these patients will be supplied pajamas, slippers and bathrobe (without cord, if there is a history of suicidal tendency). Any prohibited article, as defined, found in possession of the patient, will be impounded and disposed of as provided.

(B) All clothing of such patients (whether personally-owned or Government-owned), and the personally-owned valuables and other effects which are brought in by them, will be carefully and completely inventoried by a hospital attendant. The items and quantities of clothing will be recorded on Form 2271, Patient's Clothing Account. Except clean handkerchiefs, no clothing worn or brought in by such patient upon his admission will ordinarily be sent to the receiving ward. All of his washable clothing will be placed in a laundry bag, after being listed. If there is evidence of vermin or of communicable disease, the laundry bag with its contents, and suits, overcoat, etc., will be sent at once to the laundry for sterilization, and the laundry superintendent so notified. Following such sterilization, these articles will be returned to the clothing room for marking. When there is no vermin or communicable disease, the clothing will be sent directly to the clothing room, for marking; and, after being marked, washable clothing will be sent to the laundry from the clothing room, for return after being laundered. Hats and shoes will be placed on racks or shelves, and suits and overcoats on hangers. Clothing, after marking, will be held in the clothing room, subject to call therefor, as needed, when these patients are transferred from the reception ward to a treatment ward.

(C) Luggage will be recorded on Form 2270, Patient's Effects Slip, and turned over to the supply officer, if ward storeroom space is not available. Miscellaneous effects, not wanted or permitted on wards, will be similarly handled, and will be recorded by the hospital attendant on patient's effects slip used to record the luggage of the patient.

(D) Valuables (including watches, jewelry, emblems, personal papers, bankbooks, checks, drafts, promissory notes, bonds and other securities), will be listed on Form 2270, Patient's Effects Slip, in duplicate, and placed in an envelope Form 2637, Receptacle for Valuables, by the hospital attendant, in the presence of the admitting officer or the charge nurse. The envelope with its contents, accompanied by the original and copy of the slip, will be delivered to the supply officer, who, after verification, will sign both copies of the slip, will retain the original, and give the copy to the hospital attendant, as his receipt.

(E) Funds of such patients, including those proffered by persons accompanying them, will be counted and then placed in an envelope Form 2637 by the hospital attendant, in the presence of the admitting officer or the charge nurse. Form 2270, Patient's Effects Slip, will be executed in duplicate. The hospital attendant will make personal delivery of such funds, with the duplicate effects slip, to the manager.



The latter, after verification, will sign both slips, give the copy to the hospital attendant, as his receipt, and transmit the funds to the agent cashier, in accordance with the procedure in R. & P. 4762.

(F) In the admission of unconscious, delirious or moribund patients, the hospital attendant, supervised and witnessed by the admitting officer or charge nurse, will take custody, without delay, of any funds or valuables upon the persons of such patients, or in their luggage, or proffered by any persons who accompanied them, and will list and deliver the effects as provided in (D) and (E).

(G) An officer of the day, serving as admitting officer in the absence from duty of the latter, will be responsible for the observance of the provisions of this paragraph. See also R. & P. 6203. If the hospital attendant is absent at the time, the officer of the day, with the charge nurse as witness, will collect, list and deliver valuables and funds, as provided.] (June 30, 1944.)

[6294. UNSERVICEABLE PERSONALLY-OWNED CLOTHING OF MENTALLY INCOMPETENT PATIENTS.- Personally-owned clothing of mentally incompetent patients, rendered unserviceable through wear and tear, damage or insanitary condition, will be listed by a hospital attendant (A) of the ward on Patient's Effects Slip, Form 2270. Upon authorization of the manager such items as socks, underwear, handkerchiefs and neckties, if insanitary or otherwise unserviceable, may be destroyed or utilized in occupational therapy.] If the unserviceable articles include shirts or outer garments - overcoats, coats, trousers, vests, suits - the manager will inform the guardian, or nearest relative if there be no guardian, of the circumstances, and will request to be instructed promptly whether it is desired that such articles are to be shipped, express collect, or destroyed at the facility. The latter will be urged as the preferable disposition, because of the condition of the articles. Appropriate action will follow receipt of the reply. If no reply be received within one month, the manager will order destruction of [the articles, or their utilization in occupational therapy or as rags]. He will proceed similarly when clothing is unserviceable because of insanitary condition, and the patient has no guardian or relative. In his first letter to a guardian or relative regarding disposition of unserviceable personally-owned clothing, the manager will ask to be advised what action is desired in future similar [circumstances,] and will suggest that he be given authority to dispose of all clothing of the patient which becomes unserviceable. If this authority be given the manager will order destruction or utilization in occupational therapy (if possible) [or as rags,] of all such unserviceable clothing, without further correspondence. After disposition of such articles has been ordered by the manager, he will sign the form and route it to the ward concerned, where it will be kept [in the patient's clothing folder. The ultimate disposition of this form will be as provided in R. & P. 6299 (C) (3) for mentally competent patients. Insanitary articles will be sterilized if proposed for use in occupational therapy.] (June 30, 1944.)

[6295. PREVENTION OF ACCUMULATION OF GOVERNMENT-OWNED AND PERSONALLY-OWNED CLOTHING; CARE OF CLOTHING.--(A) See R. & P. 6288 for instructions to be given the guardian or nearest relative of a mentally incompetent applicant for hospital treatment, relative to the personal clothing and toilet articles which should be brought in upon his admission.

(B) As need arises for additional clothing or other personal effects of these patients, guardians or nearest relatives will be requested to supply the articles, which will be specified as to items and quantities desired.

(C) When personally-owned serviceable clothing or other personal effects of mentally incompetent patients have accumulated in storage and will not be needed, managers will request guardians or nearest relatives to accept return of the surplus articles. If any such accumulated articles are unserviceable, the procedure in R. & P. 6294 will be followed. When the total of personally-owned and Government-owned clothing is in excess of current needs, it will be reduced by first withdrawing Government-owned clothing; and then, if necessary, by requesting guardians or relatives to accept custody of personally-owned clothing.

(D) Ward personnel will exercise due protection of all clothing of mentally incompetent patients against loss or destruction. Care will be taken to keep these patients clothed as cleanly as their mental condition makes possible. When leaving the wards for outdoor exercise or occupational therapy, they are to be fittingly clad. Inventories will be made at appropriate intervals to ascertain the condition of the wardrobe of such patients, to determine whether any articles thereof are unserviceable or missing, and whether supplementary articles are to be requested of guardians or relatives, or procured from funds to the credit of such patients, or furnished from stock to those found financially unable to supply the articles at their expense.] (June 30, 1944.)

[6296. REQUISITIONS FOR CLOTHING, COMFORT ARTICLES TO BE PAID FOR FROM FUNDS TO CREDIT OF MENTALLY INCOMPETENT PATIENTS, AND FOR CASH.--(A) For preparation of Form 2675a in requisitions for incidentals, see R. & P. 4770; for clothing, see R. & P. 4771, and for cleaning, pressing, altering and repairing of clothing, see R. & P. 4772.

(B) For preparation of Form 2675 in requisitions of cash, see R. & P. 4769.] (June 30, 1944.)

[6297 canceled June 30, 1944.]

## EFFECTS OF MENTALLY COMPETENT PATIENTS

6298. [PROFFER OF CUSTODY OF FUNDS AND VALUABLES TO BE MADE TO PATIENTS UPON ADMISSION.--Incoming mentally competent patients will be informed, upon hospital admission, that their funds and valuables (as defined in R. & P. 6292 (D)) will be accepted for safekeeping; and that the Veterans Administration will assume no responsibility for subsequent loss of any funds or valuables not so turned over. A notice conveying the same information will be posted on a facility bulletin board or boards. If they decline to turn over funds or valuables or both, they will be requested to sign a station form, reading:

"I decline to offer funds and valuables now in my possession, for safekeeping by the Veterans Administration."

If such signature is refused, the admitting physician will so state across the face of the form, and add his name and date. These forms, whether signed or unsigned by patients, will be filed in their facility correspondence files.] (June 30, 1944.)

6299. [CUSTODY OF EFFECTS OF MENTALLY COMPETENT PATIENTS.--(A) Funds proffered for safekeeping by these patients, or by persons accompanying them upon admission, will be handled as provided in R. & P. 6292 (E). For eventual disposition of such funds, see R. & P. 4766, Finance.

(B) Valuables will be handled as provided in R. & P. 6292 (D).]



(C) Clothing and Luggage. (1) Trunks, suitcases, boxes or parcels of competent patients will be kept wherever possible in ward storerooms, when such space is available on wards, or such articles may be stored in space other than ward storerooms - either storage space under the custody of ward personnel or under custody of the supply officer. Any clothing actually needed for wear by patients when ambulant, as well as other personal effects, such as games, musical instruments, etc., the possession of which is permitted by ward physicians, will be kept neatly in individual ward lockers. Articles, the possession of which is permitted patients on wards, should be such as will promote their cheer and comfort without disturbing other patients and without causing annoyance or disorder on wards. Extra clothing or other personal effects which are not needed, or the possession of which is not permitted on wards, will be placed in the patients' trunks or hand luggage, in the ward storeroom or other storeroom. Keys to such luggage will remain in possession of the owner. If access to such stored luggage, whether in ward storerooms or storerooms in other places under supervision of ward personnel, is desired by the patient, he will be accompanied to the storeroom by an attendant. The attendant will observe the abstraction of any article or articles by the patient from his luggage and will assure himself that the abstracted article is one that is permitted on the ward. If the attendant notes that the luggage contains any contraband article (firearms or other weapons, cartridges, alcoholics or narcotics or medicines for self-administration), he will impound these articles. If a beneficiary desiring access to stored luggage is a bed patient, the luggage (except trunks) will be brought to his bedside, to be opened by him in the presence of the ward nurse or attendant, and the luggage will then be returned to the ward storeroom after the desired and permitted article or articles have been abstracted. The attendant accompanying a beneficiary desiring to abstract articles from his luggage will never leave the beneficiary until the transaction is completed, and the door of the storeroom will then be securely locked.

(2) Luggage of patients, with or without contained clothing, kept in storerooms on wards or elsewhere, but not in the custody of the supply officer, will be the responsibility of employees of the ward concerned.

[(3) Records.--(a) Clothing of these patients, whether personally-owned or Government-owned, which is not turned over to the supply officer, will be recorded by a ward attendant on Form 2271, Patient's Clothing Account. Luggage not turned over to the supply officer will be recorded on Form 2270, Patient's Effects Slip. These records will accompany the patient in transfers between wards or from wards to domiciliary barracks at the same station. Upon discharge, death, absence without leave, or transfer to another station, Form 2271, Patient's Clothing Account, or other clothing records will be incorporated in the beneficiary's clothing folder, and that folder will be placed with inactive records for three years, upon expiration of which time recommendation will be made for disposition as inactive records.

(b) When personally-owned clothing becomes unserviceable, Form 2270, Patient's Effects Slip, will be executed with the patient's signed indorsement "Disposition with my consent." If such consent be refused, and the clothing is not insanitary, no further action will be taken. If the clothing be insanitary the ward physician will certify "Listed articles insanitary; patient refuses disposition; destruction recommended" upon the said form and route it to the manager. The latter has authority to order destruction upon such recommendation and, if he does so (by incineration) and destruction is reported to him, will certify the form "Destruction



effected," with date, and route it to the patient's ward, for filing with Form 2271, Patient's Clothing Account. Instead of destruction, the manager may direct use of such insanitary clothing in occupational therapy or as rags, provided that prior sterilization of the clothing is ordered before such disposition.] (June 30, 1944.)

6300. [RECEIPT OF FUNDS FROM RELATIVES, GUARDIANS OR FRIENDS OF PATIENTS.--When relatives, guardians or friends visiting facilities desire to leave funds for patients at hours when the agent cashier is not on duty, ward physicians or nurses in charge of wards concerned will receive such funds, and will execute Form 2815, Preliminary Receipt for Patient's Funds, in duplicate. The original will be given the donor. The funds, placed in an envelope and sealed, with name of patient and donor, date and hour of receipt, total contained, and signature of the recipient, will be entered on the face of the envelope. In the case of incompetent patients, the copy of the Form 2815 and envelope will be delivered to the manager, who, upon verification, will indorse the Form 2815 and give it to the ward physician or nurse in charge as a receipt, and forward the funds to the agent cashier. In the case of competent patients, the delivery of such funds will be made direct to the agent cashier, who will verify the amount of funds and indorse and return the Form 2815 as indicated above.] (June 30, 1944.)

6301. [REIMBURSEMENT FOR LOSS OR DAMAGE OF PATIENTS' PROPERTY.--For damage or destruction, by fire, of personal property of hospitalized patients, while such property was in possession of the Veterans Administration at the time of the damage or destruction (e.g., in storage or being laundered), those patients may be reimbursed (see R. & P. R-6075-6077). The only authorization for payment for loss or damage of such personal property other than by fire is conveyed in the Act of December 28, 1922 (42 Stat. 1066), which allows settlement of reimbursement claims not to exceed \$1,000, when it can be shown that such other loss or damage resulted from negligence of an officer or employee of the Government, acting within the scope of his employment. Such claims are reported, by central office, to the Congress. The patient is to file a claim, incorporating a list of the articles alleged to have been lost, damaged or destroyed; their kind, number of each, prices paid, condition at time of the loss, etc., and evaluation of the articles as of that time. The claimant will attach to the list a statement showing how, when and where the incident occurred. The manager will appoint a board of survey which will question employees concerned in the handling and custody of the articles, and will develop the best information obtainable as to their kind, number and condition at the time of the alleged loss, damage or destruction. Report of the board's findings, with recommendation as to propriety of reimbursement and fixation of responsibility, will be made to the manager, who will forward a copy of the board's report with his comment and recommendations, to the medical director. The medical director, through channels, will transmit the claim and other papers to the solicitor, with comment and recommendation.] (June 30, 1944.)

6302. [CANTEEN CARDS FOR MENTALLY INCOMPETENT PATIENTS.--(A) At facilities for neuropsychiatric patients where there is a concessionaire, the managers are empowered to arrange for the procurement of canteen cards or books for use by a mentally incompetent patient who cannot be issued cash, for expenditure, from funds to his credit at the facility. If the manager decides that procurement of a canteen card or book is in the best interest of the individual patient, he will observe the following procedure in their procurement:



(B) Canteen cards or books will be requisitioned in the manner prescribed for purchase of incidentals for a mentally incompetent patient with funds to his credit (see R. & P. 4770). Public vouchers covering purchase of such cards or books will be handled promptly by the finance officer in accordance with governing regulatory and procedural instructions. Payment for canteen cards or books cannot be made in advance, but only after the services or articles furnished through such medium actually have been received and certification made to that effect.

(C) Canteen cards or books will be stocked by the concessionaire, and will have a value of \$1 to \$3. The coupons or punch figures will be denominations of 1, 5 and 10 cents. The card or book will be signed, as owner, by the patient to whom it is issued; and the concessionaire will honor only the cards or books presented by their owners. Canteen cards or books will not be procured for patients whose guardian or nearest relative objects to such purchase.] (June 30, 1944.)

[6303 canceled June 30, 1944.]

#### FURNISHING, ALTERATION, REPAIR, CLEANING AND PRESSING OF CLOTHING AT GOVERNMENT EXPENSE

[6304.] AUTHORITY TO FURNISH.—(A) Clothing may be furnished at Government expense to beneficiaries receiving hospital treatment or domiciliary care in Veterans Administration facilities, when (1) necessary for protection of health or for sanitary reasons, and (2) when such beneficiaries are without means and are receiving less than \$10 a month from any source. [Both of these conditions must be met. Regular gifts of funds from guardians or relatives of beneficiaries will be taken into consideration in determining eligibility. Occasional gifts will not necessitate a determination of eligibility to continuance of the furnishing of clothing; the furnishing will be temporarily discontinued until the gift of funds is exhausted, and can then be resumed without redetermination of eligibility. Mentally incompetent patients] having adequate available funds in the hands of guardians, moneys in special trust funds (such as Patients' Funds or Funds Due Incompetent Beneficiaries), or elsewhere, will not be eligible for furnishing of clothing at Government expense. [ ] When it is established that any beneficiary, although in receipt of \$10 or more monthly, is continuously contributing any portion thereof to dependents, so as to reduce his monthly income below \$10 for his personal use, and condition (1) is met, the manager of the facility, or an employee designated by him, may authorize the furnishing of clothing. A father or mother may be considered a dependent, as well as a wife or children, but the fact as to dependency must be clearly established. The possession of an adjusted service certificate or adjusted compensation bond will not be regarded as income for the purposes of this paragraph, but only funds derived from an adjusted service certificate, adjusted compensation bonds, or any other source, must be taken into consideration in determining eligibility to have clothing furnished at Government expense. [A beneficiary who has assets which may be liquidated (such as negotiable securities, checks, drafts, etc.,) is not "without means." If the income from any such assets does not reach \$10 or more monthly, the assets may be liquidated to the level of that monthly income.] Any and all funds in excess of \$75, regardless of the source, which may accumulate to the credit of a beneficiary from income of less than \$10 monthly will be applied to the purchase of required clothing.



(B) Clothing furnished beneficiaries, or personally-owned by them, may be altered, repaired, cleaned and pressed, subject to the conditions of [(A)]. (June 30, 1944.)

**[6305.] CONDITIONS TO GOVERN.**—(A) Managers will be held responsible for due economies in furnishing, altering, repairing, cleaning and pressing of clothing for beneficiaries. There is no obligation to furnish service except to meet actual needs, carefully determined. Determination of need will be based solely upon protection of health or sanitary reasons.

(B) The beneficiary must be receiving hospital treatment or domiciliary care. Persons admitted to facilities for observation; those reporting to facilities for out-patient physical examinations, who are held over and provided lodging and meals to complete examination; and those referred to facilities for spinal puncture, artificial pneumothorax, intravenous medication, metabolic tests, etc., will not have clothing furnished, altered, repaired, cleaned or pressed. In general, patients requiring brief periods of hospital treatment will not be supplied such services except for clearly determined protection of health or sanitary reasons. (June 30, 1944.)

**[6306. DETERMINATION OF ELIGIBILITY.**—(A) Determination of eligibility, under R. & P. 6304 and 6305, for the furnishing, altering, repair, cleaning and pressing of clothing at Government expense, will be made by an eligibility clerk, to whom will be referred all applications for clothing (Form 2686 revised), and all notices of amended awards (Form 653) received from adjudication agencies.

(B) Applications for Clothing, on Form 2686, originating on wards or barracks, will be routed to the finance officer, who will record, at the top of the front of the form, the amount of funds to the credit of the applicant, and will then send the application to the eligibility clerk (for assignment of this employee, see R. & P. 6110 (D)). The latter, from the statements on the application, the notices of amended awards, and such data relative to economic status as appear on the beneficiary's Form P-10, will determine his eligibility, reflecting his decisions by the respective indorsements, in ink, "Eligible" or "Not Eligible," followed by his initials and date, at the bottom of the front of the Form 2686 revised. The case file of the applicant may be consulted by the eligibility clerk, if necessary, or data from that file requested from such other field station as may be in possession of that file. Applications indorsed "Not Eligible" will be routed by the eligibility clerk to the ward or barracks where they originated. The nurse in charge or company commander, after noting the indorsement, will mark that Form 2686 "Place in Correspondence File," and will route it accordingly. Applications indorsed "Eligible" will be sent by the eligibility clerk to the chairman of the clothing committee of the facility, for determination of the need for the requested service and the extent to which it is to be rendered. For further procedure of the clothing committee, see R. & P. 9039, Supply. All action having been taken upon the recommendation of the clothing committee, the Form 2686 revised will be placed in the beneficiary's correspondence file.

(C) Applications for alteration, repair, cleaning or pressing of clothing will be made on Form 2686a, and will be handled as provided in (B). Determinations for cleaning and pressing will be made by ward physicians and by domiciliary officers or company commanders, respectively.

(D) No clothing will be supplied at Government expense, or any clothing be altered, repaired, cleaned or pressed, except upon application as provided.



(E) No card index or other records related to eligibility of patients or members for the furnishing, alteration, repair, etc., of clothing will be maintained by the eligibility clerk. That employee, upon receipt of a Form 653, showing an amended award, will route it for incorporation in the beneficiary's correspondence file which, as provided in (B) will also contain all Forms 2686 and 2686a that had been indorsed "Eligible" or "Not Eligible." The current status of any applicant for clothing, or alteration, repair, etc., of clothing is accordingly readily determinable by the eligibility clerk from the applicant's correspondence file. He will procure those files and make such determinations whenever he receives applications on Forms 2686 or 2686a.] (June 30, 1944.)

[6307.] CLOTHING FOR WOMEN.—Eligible women beneficiaries may be furnished Government clothing equivalent to that approved for males, as well as alterations, repairs, cleaning and pressing, subject to the foregoing provisions. (June 30, 1944.)

[6308.] SPECIAL CLOTHING.—(A) Where the wearing of a prosthetic appliance makes necessary the furnishing of special clothing, such clothing may be furnished, altered or repaired, as provided in R. & P. R-6115 for beneficiaries receiving hospital treatment or domiciliary care or receiving out-patient treatment. The proper significance must be attached to "Special" clothing. A complete clothing outfit is not to be furnished merely because of the wearing of an artificial limb or brace. The prosthetic appliance must be of a kind that cannot be worn with ordinary clothing, but must be one actually requiring special clothing. Examples are a neck brace requiring lengthening and broadening of a coat collar, or reinforcement with leather at a point of wear, etc. Special clothing is not furnished as clothing per se, but as an adjunct to a prosthetic appliance.

(B) Application for special clothing will be made on Form 2686 in duplicate. Since not furnished as clothing per se, the application need not be passed upon as to financial eligibility, but will be referred directly to a board which will function on all such applications. The chairman of this board will be the chief medical officer or the clinical director, or a physician, preferably with orthopedic training, designated by either. The other member will be: For hospital patients, the physician of the ward concerned; and for barracks members, the domiciliary officer. The board so composed will give careful consideration to the possibility of altering clothing already in use by the applicant (either previously furnished by the Government or personally-owned), rather than furnishing and altering new units. What is furnished as new, should only be such article or articles of clothing as are actually affected by the wearing of the prosthetic appliance. The board, upon conclusion of the determination, when a supply or alteration is to be made, will route the completed Form 2686 to the supply officer for necessary action.

(C) Special clothing may be permitted to be worn by beneficiaries upon discharge or when proceeding upon permitted leave of absence or furlough, or trial visit, and when transferred to another facility.] (June 30, 1944.)

[6309.] PENALTIES FOR WILFUL DAMAGE, DESTRUCTION OR LOSS OF GOVERNMENT-SUPPLIED CLOTHING.—(A) Employees will require that beneficiaries take proper care of clothing supplied them by the Government, and will report to the manager, through channels, any instance of failure on the part of recipients of such clothing to comply with their agreement on Form 2686. If, through report by an employee or during the taking of inventories or inspection, it appears that a beneficiary has lost, damaged or destroyed such clothing through his wilful misconduct or carelessness, or has sold,



pawned, bartered or otherwise disposed thereof, the manager when such offense is reported to him will, if the offender be a hospital patient, refer the allegations to the chairman of a hospital board of discipline or, if the offender be receiving domiciliary care, proceed under R. & P. 7868, relative to manager's court. Whenever possible, the supply officer or his representative will be designated as a member of the hospital board of discipline in such cases. Under charge 2, "Infraction of discipline", the specification will be particularized as "Loss, or damage or destruction of"; or "Sale, barter or pawning" of Government clothing as called for by the circumstances.

(B) If the board finds the accused not guilty of the charge, and the manager approves the findings and recommendations, he will have the papers routed to the patient's correspondence file for filing. If the board makes a finding of guilt, its recommendation will be for a major penalty, or for a minor penalty or combination of minor penalties, as prescribed, dependent upon the relative gravity of the offense. If the offense be grave, justifying recommendation of discharge from the facility (with its associated penalties of exclusion from readmission for a prescribed period and denial of return transportation from the facility), but the offender's physical condition will not permit of discharge with safety, the punitive measures will appropriately include a combination of minor penalties (e.g., refusal of passes, denial of attendance at entertainments, for a sufficient period). Upon a finding of guilt by a manager's court, the penalty will be as prescribed in R. & P. 7868. Completed papers will be filed in the beneficiary's correspondence file.

(C) Mentally incompetent patients will not be subject to the charges and penalties provided in this paragraph. (June 30, 1944.)

#### TOILET ARTICLES, BARBER SERVICE, TOBACCO, ETC.

6312. AUTHORITY TO FURNISH.--(A) To beneficiaries receiving hospital treatment or domiciliary care in facilities under direct and exclusive jurisdiction of the Veterans Administration there may be supplied, subject to the conditions hereinafter specified, these articles and services, in whole or part as determined needed: hair combs, hair brushes, tooth brushes, denture brushes, toothpaste, safety razors, safety razor blades, shaving brushes, shaving cream or shaving soap, barber service, smoking tobacco, cigarettes, pipes, matches, shoe polishing, postage stamps, writing paper and letter envelopes. (June 30, 1944.)

(B) Except as provided in R. & P. 6313, such beneficiaries may be provided the said articles and services when they are in receipt of less than [\$10] monthly income from any source. The general eligibility criteria in R. & P. 6304, governing the furnishing, etc., of clothing, including availability of assets, etc., will apply to the furnishing of the articles and services specified in (A). Any and all funds in excess of \$75, regardless of the source, which may accumulate to the credit of a beneficiary from an income of less than [\$10] monthly will be applied to the purchase of toilet articles, tobacco, etc. (June 19, 1945.)

6313. CONDITIONS TO GOVERN.--(A) Patients admitted for hospital observation and examination, or for completion of an out-patient examination, or for a diagnostic or treatment procedure (spinal puncture, metabolic test, intravenous medication, artificial pneumothorax, re-irradiation, etc.), though otherwise eligible, will not be supplied any of the articles and services in R. & P. 6312 (A) except upon careful



medical determination of the necessity for toilet articles (such as a tooth brush, toothpaste) as a hygienic measure.

(B) An applicant who, with no other monthly income, has been awarded [\$10] or more monthly by the Veterans Administration but is not yet in receipt of payments may, pending such receipt, be supplied the toilet articles actually necessary for hygienic reasons. (June 19, 1945.)

(C) Regardless of the amount of their monthly income, neuropsychiatric beneficiaries under treatment in facilities for neuropsychiatric patients or in other facilities having a separate unit for such patients, will be furnished (1) a standard toothpaste, available through the supply service; and (2) barber service, to include haircutting and shaving.

(D) Shoe-shining facilities, furnished as hereinafter provided, may be utilized by any beneficiary, regardless of the monthly income provisions of R. & P. 6312 (B). (June 30, 1944.)

6314. APPLICATIONS; ELIGIBILITY DETERMINATIONS.--(A) (1) Before any beneficiary is furnished any of the articles or services, he will be required to execute the following application form (original, no copy) to be mimeographed at facilities. Applications for a mentally incompetent patient will be executed by his ward physician, who will affix the patient's name, followed by his own. Domiciliary officers will have like authority for infirm or senile members.

APPLICATION FOR TOILET ARTICLES, BARBER SERVICE, TOBACCO, ETC.

Vets. Adm. Fac. \_\_\_\_\_  
(Location) (Date)

I, \_\_\_\_\_ request that I be furnished at Government  
(Name of Beneficiary) (Register No.)

expense, the service or services, and article or articles, with kind and units, as checked by me on the following list. I am financially not able to supply these articles at my expense. I am not in receipt of income for my personal use, from the Government or any other source to the amount of [\$10] or more monthly, and do not possess any of the articles I am requesting. The article or articles requested are for my personal use. I fully understand that if I sell, barter, damage, destroy or lose, through my carelessness or misconduct, any article supplied me, I shall be subject to penalty as provided.

ARTICLES OR SERVICES	KIND	UNITS
Barbering		
Blades, safety razor		
Brush, hair		
Brush, shaving		
Brush, tooth		
Brush, denture		
Cigarettes		
Comb, hair		
Cream, shaving		
Envelopes		
Matches		

ARTICLES OR SERVICES	KIND	UNITS
Paper, writing		
Paste, tooth		
Pipe		
Razor, safety		
Soap, shaving		
Stamps, postage		
Tobacco, smoking		

(Check items desired, and draw line through items not requested. The hospital attendant or company commander will explain how to fill in "kind" and "unit".)

(Designation of Ward or Barracks)

(Signature of Applicant)

Approved: \_\_\_\_\_

Disapproved: (Signature of Ward Physician or Company Commander)

[ ]

(2) The mimeographed forms, prepared after this model, will be on sheets of 8" x 10½", letter size. Both sides will be used - the back for list of articles, signatures, etc. For neuropsychiatric facilities, the items of razor blades, matches and safety razors will be omitted.

(3) Hospital attendants and company commanders will instruct applicants regarding entries under "kind" or "unit"; for example, enter under "kind", the make of cigarettes wanted (Camel, Chesterfield, Paul Jones, etc.), or make of razor blades (such as can be supplied), etc., and, under "units", the number and package, as 1 tube (shaving cream or toothpaste), 4 pkgs. (cigarettes), 4 (razor blades), 1/2 lb. (tobacco), etc. To render this assistance, these employees will familiarize themselves with conditions controlling the furnishing of such articles and services, the amounts authorized, and the types and brands of articles available for supply.

(4) Applications, thus completed, will be carefully scrutinized by nurses in charge and company commanders, with regard to the personally-owned toilet articles, if any, brought in by the beneficiary upon his admission, or subsequently procured by himself or as gifts from relatives or friends. If an inspection of the amount and condition of such toilet articles does not show him to be in actual need, immediate or at all, of any article or articles he applies for, nurses in charge or company commanders must feel no hesitancy in deleting with red ink such item or items from his application, affixing their initials opposite the deletions. Always it must be kept in mind that the Government is not obligated to make issues of toilet articles or services to beneficiaries unless there is a determination of actual need therefor.

(B) ELIGIBILITY DETERMINATIONS.--[After such scrutiny and correction of the applications, they will be forwarded to the eligibility clerk (for assignment of such employees - see R. & P. 6110 (D)), who will check them against the applicants' Forms P-10 and any notices of amended awards (Form 653) received from adjudication agencies, as provided, to ascertain if the applicants are in receipt of income sufficient to bar them. Case files of the applicants, if in possession of the station, may be consulted by the eligibility clerk making these determinations of financial eligibility. He will write, in ink, "Not Eligible" or "Eligible," as determined, followed by his initials and date at the top of the application. All applications, whether certi-



fied eligible or not eligible, will be returned by the eligibility clerk to the ward or barracks designated on the form; except that forms for "interval" issues will be routed directly to the pharmacist or other employee, as hereinafter provided, who will be responsible for interval issues. The application forms, however certified, which are returned to wards or barracks or sent to the employee making interval issues, will, after being carefully noted, be filed in manila folders to be kept, in a locked receptacle, on the wards or barracks or by the pharmacist, etc., to guide in the preparation of requisitions for toilet articles, etc. The eligibility clerk will supply (on station form) nurses in charge and company commanders, as well as the employee dispensing stationery (see R. & P. 6317 (C)) with notices of change in financial status of beneficiaries. Such notices, after appropriate action (removal from or addition to the list of eligibles of the names of beneficiaries in such notices) will be maintained in the manila folder that contains the application forms, or in a manila folder marked "notices of change in eligibility for toilet articles, etc." See R. & P. 6320 as to disposition of records.]

(C) CONTINUANCE OF SERVICE UNTIL ELIGIBILITY IS CHANGED OR OFFENSES ARE COMMITTED.--Once eligibility is thus determined on initial applications, the applicant will thereafter be entitled to continuance of the supply of articles or services until his income status is so changed as to make him ineligible, or until it is found that he has sold, bartered, damaged, destroyed or lost any article through his carelessness or misconduct. Company commanders and ward physicians, nurses, attendants and other employees will be expected to observe the utilization of any article or service supplied beneficiaries; and if any employee has observed or been informed of the sale, barter, damage, destruction or loss (through carelessness or misconduct) of any article supplied a beneficiary, the employee will report the facts, through channels, to the manager. When the alleged offense is the first charged against the beneficiary, - and especially in cases in which the charge involves a comparatively minor offense, such as loss or damage of an article - the manager may personally investigate the charge, and decide whether, in his judgment, it is sustained; or, - especially when the alleged first offense is relatively more grave, as in sale, barter or wilful destruction of an article - the manager may order a formal hearing before a hospital board of discipline or manager's court. But when a beneficiary who, within one year previously, had been found guilty of the sale, barter, damage, destruction or loss of any article aforesaid, is again accused of a like offense, there will be a hearing before a hospital board of discipline or manager's court, as jurisdiction lies. The manager will approve or disapprove, in whole or part, the recommendations of such hospital board of discipline. He will have full authority to order infliction of any applicable penalty, as prescribed. (June 30, 1944.)

[6315.] PENALTIES.--(A) FIRST OFFENSE. - Denial of tobacco or cigarettes and matches, denial of passes and of the privilege of attending entertainments, for a period of one to six months. The denial of tobacco or cigarettes will apply in any such case, but a combination of this denial with any of the other penalties may also be inflicted, depending upon the relative gravity of the offense. For minor offenses - such as loss or careless damage to an article, when there might be some extenuating circumstances, - the denial of tobacco or cigarettes and matches and the refusal of passes, for a period of one to three months, would be appropriate. For sale, barter or wilful destruction of an article, the withdrawal of the supply of tobacco or cigarettes and matches, and denial of passes or privilege of attending entertainments for from three to six months would be in order.



(B) REPETITION OF OFFENSE.--A hospital board of discipline or manager's court will, in a finding of guilt upon a second charge made within one year after a previous offense, recommend denial of any tobacco, cigarettes, matches, granting of passes and privilege of attending entertainments, for a period of one year.

(C) The manager, upon ordering infliction of any penalty will have sent immediately to the ward physician or company commander concerned a typed notice thereof, for information and guidance, and to accompany the offender in an intra-station transfer. A duplicate of this notice will be supplied the employee designated to make eligibility determinations, who will retain and be guided by it during the prescribed period of penalty, if the offender remains in the hospital, home or center. To insure continuance of the penalty when the offender is discharged or receives an inter-station transfer, the following procedure will be observed: Upon transfer, the copy of the Form 2649, Request for Inter-facility Transfer, which is sent to the receiving station will have typed on its back a short statement of the nature of the penalty imposed, the date of its infliction and the period for which it is to run. In discharges of an offender, the completed Form 2593, Record of Hospitalization or Domiciliary Care, will carry a similar statement, under "Remarks", on its back. Whenever a regional office or center, in possession of an applicant's case file, forwards a Form P-10, Application for Hospital Treatment or Domiciliary Care, to a station, the Form 2593 in the case file will be consulted, and the data thereon, relative to discharges for infractions of discipline and as to penalties inflicted for sale, barter, damage, destruction or loss of toilet articles, etc., furnished, will be transmitted with the Form P-10. If such data are not so received by the station admitting the applicant, they will be promptly requested from the regional office or center in possession of the case file, as ascertained from Form P-10, or can be obtained from the copy of Form 2593 submitted to the director, budget and statistics, central office.

(D) PENALTIES NON-APPLICABLE TO INCOMPETENT PATIENTS.--None of the foregoing penalties will be applicable to mentally incompetent patients.

(E) CLEARANCE OF PENALTIES.--Upon expiration of the period of penalty of from one to six months, as imposed for a first offense, or one year after a finding of guilt and date of infliction of penalty for a second offense, the beneficiary will thereafter be entitled to any issue of any article or service enumerated so long as he is eligible therefor and until commission of another offense. (June 30, 1944.)

6316. BARBER SERVICE. (A) FOR NEUROPSYCHIATRIC PATIENTS.--Irrespective of their financial status, neuropsychiatric patients, (1) in hospitals, homes or centers primarily for such patients, or (2) in hospitals, homes or centers which, while not primarily for such patients have under hospitalization a segregated considerable number of such patients - will be supplied barbering service (shaving and hair cutting). Such of these neuropsychiatric patients as are determined to be unquestionably mentally competent to shave themselves with safety razors may be allowed to do so, but always under immediate supervision of attendants; safety razors or blades will not be issued to nor allowed in possession of such mentally competent patients, except while they are shaving. Mentally incompetent patients will never be allowed possession or use of razors or blades of any kind. The shaving of mentally incompetent patients will be done with safety razors by ward attendants in addition to their other duties, or by station barbers, with safety razors or open razor, if the latter type of razor is approved by the manager. Hair cutting of patients comprehended under this paragraph will be done by station barbers (contract or otherwise) or other qualified employees.



(B) FOR TUBERCULOUS OR GENERAL MEDICAL OR SURGICAL PATIENTS OR DOMICILED MEMBERS.--

Subject to the conditions of R. & P. 6314, these will have their hair cutting done by a station barber or other qualified employee. If able to shave themselves, they may be furnished safety razors, blades and shaving cream or soap. If physically incapacitated to shave themselves they will be shaved by hospital attendants, in addition to their other duties. Domiciled (barracks) beneficiaries, subject to the conditions in R. & P. 6314, will have their hair cutting done by a station barber or other qualified employee. They will be required to shave themselves. However, these domiciliary members who are entitled to free hair cuts and who are medically determined as being unable to shave themselves because of age or disability, will have shaving and hair cutting provided by the station barber (contract or otherwise) or other qualified employee, such members to be shaved twice each week.

(C) WHAT BARBER SERVICE COMPREHENDS.--The services of a barber, insofar as provided at Government expense for beneficiaries under (B), will consist solely of hair cutting done not more than once each month; provided, however, that certain domiciled (barracks) beneficiaries may have shaving provided by a station barber or other qualified employee, as provided in the preceding subparagraphs. Shampooing, facial massage, etc., will not be supplied at Government expense. If there is sufficient hair cutting to be done for beneficiaries to require at least 50 percent of the time of a barber, a part-time or full-time barber may be employed, or this service may be obtained under contract, if this is advantageous. When less than 50 percent of an individual's time would be required to furnish hair cuts, hair cutting will be done by ward attendants having the necessary qualifications, and such qualifications will be borne in mind in employing attendants. (June 30, 1944.)

6317. AMOUNTS OF ARTICLES TO BE SUPPLIED.--(A) Articles will consist only of those mentioned in R. & P. 6312. Barber equipment and tools may be provided and installed when necessary. Not to exceed 6 safety razor blades of makes specified for requisition may be supplied monthly. Not to exceed 1 tube of shaving cream or 1 bar of shaving soap, and 1 tube of toothpaste may be supplied monthly. Tooth brushes supplied not less than 3 months before may be exchanged for new issues, except that, when special need exists and particularly with regard to psychotic patients, such exchange may be oftener made. Hair brushes, hair combs, razors and shaving brushes and denture brushes will not be resupplied after these have been initially furnished; except that when any such article has been lost through no fault of the beneficiary, another such article may be supplied or, when any such article becomes worn or damaged through fair wear and tear, it may be exchanged for a new article. The foregoing maximum supply of toilet articles for one month's use will necessarily be reduced to meet differing circumstances, such as admissions between regular monthly requisition days, impending discharge or transfer, within a few days, etc. A beneficiary admitted in an interval between regular monthly requisitions will receive 1 safety razor blade for each 5-day period or part thereof up to the next monthly issue, and a fractional supply of matches, writing material, stamps or postal cards. To a beneficiary about to be discharged within 5 days or less, 1 safety razor blade will be issued, and exchange of other articles, as provided, will not be made. However, not less than 1 tube of toothpaste or shaving cream will be supplied beneficiaries receiving interval issues or those about to be discharged or transferred within a few days. (June 30, 1944.)

(B) TOBACCO AND CIGARETTES.--An issue of 1 pound of smoking tobacco (pipe) may be made each month to beneficiaries receiving hospital treatment or domiciliary care on the issue day. To beneficiaries admitted between days of issue, there may be sup-

plied 1/2 pound of smoking (pipe) tobacco for any period of 15 days or less up to the next issue day, or 1 pound if they are admitted more than 15 days before the next regular monthly issue day. In lieu of smoking (pipe) tobacco, [a maximum of 12 packages] of cigarettes specified for supply, or 12 bags of cigarette tobacco may be supplied each month. To beneficiaries admitted between monthly issue days, there will be given such units of the monthly supply of cigarettes or cigarette tobacco as represent proportional fractions of the full monthly supply. These issues will be subject to these conditions: that the use of tobacco or cigarettes is not disapproved by a [station] physician, and that tobacco or cigarettes will be issued only to known users thereof and only for the personal use of such recipients. Any beneficiary found to be selling or bartering tobacco or cigarettes so issued will be penalized as provided in R. & P. 6315. Issue of chewing tobacco is not authorized. For beneficiaries whose discharge is expected within a week or less, 1/2 pound of tobacco may be supplied, if smaller units are not available, but cigarette issues to such beneficiaries will be fractioned, as prescribed. (February 8, 1946.)

(C) SHOE-SHINING SERVICE; WRITING MATERIALS; MATCHES.--(1) For general use of beneficiaries, a shoe-shining service will be made available, consisting of a bench or benches (fabricated as an occupational therapy project or by the station carpenter), equipped with the necessary amounts of black and tan polishes and shoe brushes. The bench or benches will be placed in a convenient location or locations, to be designated by the manager.

(2) Scratch tablets or writing paper (8 x 10½ inches), a small supply of plain envelopes (3½ x 6 inches), and a small supply of postage stamps; or, for ordinary communications, not private in nature, one-cent postal cards will be supplied upon requisitions at necessary intervals to an employee (such as a recreational worker, occupational therapy aide, librarian or other employee designated by the manager) to be issued to entitled beneficiaries. Sufficient leaves detached from the tablet and one or more envelopes, or a postal card or cards, as required, will be supplied at a time. Postage stamps (to mail not to exceed two first-class letters per week and not to exceed six cents per week for each entitled beneficiary) will be affixed to beneficiaries' letters by the employee or employees designated. In lieu of stamps, postal cards may be furnished not to exceed two per week. The name of the beneficiary must be written upon the back of the envelope. A list, revised monthly, of beneficiaries will be maintained at the desk of the employee or employees designated to check issues of envelopes, writing paper, stamps, and postal cards. Pens and ink will be made available in recreation rooms, and for bedfast patients on wards. Use of postal cards will be encouraged for all correspondence not confidential in character. (June 30, 1944.)

(3) Safety matches, book-type only (20 matches to the book) will be supplied monthly to eligible smokers only, as follows: 18 books with each pound of pipe tobacco, with 12 packs of cigarettes, or with 12 bags of cigarette tobacco. Fractional quantities will be furnished beneficiaries not entitled to these monthly maximum issues. These supplies of matches will be issued to company commanders and to attendants (A) on hospital wards, to be reissued by them to entitled beneficiaries. Only such amounts of matches will be issued as will avoid carrying a stock on wards or in barracks. No matches will be issued to mentally incompetent beneficiaries; the attendants (A) will draw and pool the allotments, for such beneficiaries, and will light their pipes or cigarettes. Station rules as to smoking places will be strictly enforced. (See R. & P. 6127.) (February 8, 1946.)



(4) Pipes may be supplied to regular tobacco users, but will not be re-supplied after the initial issue, except that, when lost through no fault of the beneficiary they may be reissued, or when worn or damaged through fair wear and tear they may be exchanged. (June 30, 1944.)

6318. PROCEDURE IN ISSUES - INITIAL SUPPLY.--An initial issue of any article or service specified in R. & P. 6312 may be made upon regular days or at intervals between such days. Either such issue will require execution of the application, as provided. Interval applications will be marked as such, i.e., "Interval Issue."

(A) INTERVAL ISSUES. (1) A beneficiary admitted between regular issue days will, if eligible, receive an interval initial issue, with amounts of articles fractioned as provided. After certification is made by the eligibility clerk, he will route each application certified ineligible directly back to the ward or barracks concerned; and will route an eligible application to the supply officer or the pharmacist, who will check and supply the articles carried in stock by him, as hereinafter provided, forwarding them to the ward or barracks concerned, accompanied by the applications. The nurse in charge or the company commander concerned will check the delivered articles against the requested items on the application and, if correct, will distribute the articles to the applicant. If such application be for services (barbering, writing paper, envelopes, stamps) besides articles, these services will be arranged for by the nurse in charge or by the company commander.

(2) If, despite fractioning of amounts of toilet articles supplied, as provided, there are left on wards or barracks any toilet articles, tobacco or cigarettes, not issued to beneficiaries or remaining after their discharge or death, such items will be sent promptly to the supply officer or the pharmacist with a covering list of the items and total amounts, identified as "Left-overs." The supply officer or the pharmacist will stock such return items, for reissue. He will keep a book (to be titled "Toilet articles, tobacco, etc.") in which he will enter such items as received. Also he will enter in this book the articles and units thereof which he furnishes to wards and barracks as interval issues, footing these totals as of the day he issues them. At the end of each month he will enter, from the daily footings, the monthly totals so issued. If the book is maintained by the pharmacist it will be open for inspection by the chief medical officer or the clinical director, who will exercise general supervision over this activity, and will, at appropriate intervals, check the pharmacist's entries of receipts and issues to wards and barracks, comparing these with his monthly requisitions upon the supply officer. If the book is maintained by the supply officer the monthly total will be transferred to and included on the monthly Expenditure List, Form 137a.

(3) On the same day that reissues are scheduled by wards and barracks, the pharmacist will, if a stock is maintained by him, prepare a Form 2598g, to be routed to the supply officer, covering a sufficient amount of all articles (except stationery, stamps and shoe polish) to meet estimated requirements of interval issues. The pharmacist will base this estimate upon the average of monthly admissions, with consideration of seasonal fluctuations. He will aim to draw only what is needed and, if at the end of the month he has a surplus stock, will proportionately reduce his requisition. The pharmacist will cooperate with the supply officer in clearing back to the latter all the stock in unbroken packages that is not moving, to prevent waste and deterioration and conserve the pharmacist's storage space.

(4) In facilities where no pharmacist is assigned or where, in the manager's judgment, the regular duties of the pharmacist are too heavy to permit his assumption



of the function of handling interval issues, the manager may designate another employee (such as the supply officer, the recreational aide, a hospital attendant (A), or a company commander) to discharge this function according to the procedure outlined above.

(B) REGULAR INITIAL ISSUES.--When an application for [an initial supply of articles or services is approved and the applicant is certified as financially eligible on the day that regular semi-monthly issues are planned for wards or barracks, such application, calling for a semi-month's supply (unless reduced as provided in R. & P. 6317] will be sent to the supply officer. The nurse in charge of the ward or the company commander concerned will make out a Form 2598g, for the approved items on the application, for signature by the ward physician or the domiciliary officer, respectively, and for reference to the supply officer. The latter will send the approved articles to the ward or barracks concerned, accompanied by the Form 2598g. The nurse or company commander will verify the deliveries and, if correct, will return the receipted Form 2598g to the supply officer and distribute the articles to the beneficiary. (June 30, 1944.)

[6319.] SUBSEQUENT ISSUES.--(A) [No applications will be executed for continued supplies of articles or services after the initial issue thereof. So long as the eligibility of a beneficiary remains unchanged, he will be supplied the subsequently necessary articles or services. But, when notice of change in financial status is communicated by the eligibility clerk to the employee dispensing stationery and stamps, and to the ward or barracks on which the beneficiary concerned is receiving treatment or care, the notified employees will take prompt appropriate action, viz., the removal from or the addition to the list of eligible beneficiaries of the name of the patient or member concerned.]

(B) Nurses in charge and company commanders will prepare one consolidated Form 2598g, Issue List - Expendable Property, to cover the total of articles needed as a supply for an issue period for all eligible beneficiaries on their wards or barracks at the time, and will forward this form to the supply officer. The latter will fill these requisitions and send the articles, with the Forms 2598g to the wards or barracks concerned, where the deliveries will be checked against the Form 2598g. If found correct, the form will be returned, receipted, to the supply officer and the articles distributed to the beneficiaries. If deliveries are not correct, the supply officer will be notified.

(C) Reissues on wards or barracks may, if considered more convenient and less liable to result in accumulations and difficulty in custody of articles, be arranged weekly [instead of semi-monthly].

(D) [ ] The continuance of services - barbering, [supply of] writing material, stamps - will be arranged by nurses in charge or company commanders, respectively.

(E) While regular periodic issues of articles or continuance of the furnishing of services for eligible beneficiaries will be authorized by nurses in charge or company commanders, ward physicians and domiciliary officers, respectively, will be expected to supervise the said employees in the exercise of this authority. If they find that this duty is not receiving proper attention, they will curtail the authority and require, so long as they think necessary, that nurses in charge and company commanders have their signatures on Forms 2598g countersigned by ward physicians or domiciliary officers. (June 30, 1944.)

[6320. RECORDS. - These consist of the application and the notice of change in financial status (see R. & P. 6314). Either, upon receipt by the employees concerned, will be placed in a manila folder, to guide in requisitioning and distribution of the articles or services. Upon discharge, death or inter-facility transfer of a bene-



ficiary, these forms may be recommended for disposition as inactive records.] (June 30, 1944.)

[6321.] OTHER COMFORT ARTICLES AND SERVICES.--Bibs, pneumonia jackets, chair covers, ice bag covers and hot water bottle covers, when determined needed, will be supplied by the Veterans Administration, as products of occupational therapy; luxury articles, such as afghans, beanies, lap robes, bedside bags, etc., as well as articles or services in connection with recreational activities, may be accepted as donations from welfare organizations, in the discretion of managers, after compliance with R. & P. 8602; except that the provisions of R. & P. 8602 need not be complied with when the gifts are designated for specified beneficiaries. Pajamas, slippers and bathrobes will be supplied during care by the Veterans Administration, but may be accepted as gifts from welfare organizations for patients being discharged or transferred as litter cases. (June 30, 1944.)

#### NATIONAL HOSPITAL DAY

[6325.] OBSERVANCE OF NATIONAL HOSPITAL DAY.--May 12 will be observed annually as National Hospital Day in all facilities under direct and exclusive jurisdiction of the Veterans Administration, and managers thereof will arrange suitable programs therefor. The cooperation of editors of local newspapers is desirable. They should be supplied information as to the services being rendered beneficiaries, such as the recreational activities, occupational therapy projects, special methods of therapy, organization of the service, bed capacity, etc., and encouraged to send photographers of their staffs to the facility to take pictures for illustrations to accompany their articles. Pictures of patients, however, will not be taken without their consent. Further publicity may be obtained by suggesting to local merchants the dressing of their shop windows with hospital displays or backgrounds. It may be possible to arrange slides in local motion picture theatres. The cooperation of Red Cross Chapters and ex-service organizations should be welcomed. Newspaper editors should be requested to publish specified hours of the day during which the facility will be open to the public. Members of the medical, subprofessional, supply and utility staffs should be designated by the manager to conduct visitors through the kitchens, dining rooms, occupational therapy and [physical therapy room, library], recreational rooms, laboratories and such wards as are selected, and to explain to them the classes of beneficiaries who are eligible for admission, the types of treatment, and other facts of interest to the public. It is clearly to be understood that there is no authority for incurrence of expense to the Government in connection with publicity or the entertainment of visitors to the facilities. (June 30, 1944.)

#### SANITATION OF FACILITIES

[6326.] SANITARY INSPECTION OF FACILITIES AND GROUNDS.--(A) At least once a week, or oftener if judged necessary, a thorough inspection of the buildings and grounds of each facility will be made, to be followed promptly by full correction of all insanitary conditions which are found. These inspections will be made by a physician - either a manager, chief medical officer, or clinical director, or by a physician designated by the chief medical officer or clinical director. The premises of concessionaires, if any, will be subject to such inspections, with particular attention to the handling of foods and beverages therein; equipment used in the storage and refrigeration of foods; condition of kitchen and eating utensils; presence of rats,



roaches and other vermin; and the general cleanliness of such premises and its employees. No report of sanitary inspections will be transmitted to central office, but the sanitary inspector will prepare, after each such inspection, one copy of a written report to the manager, sufficiently detailing his findings, his orders for correction, and extent of accomplishment of his orders. The manager, after considering such reports, will have them filed in his office for inspection by supervisors of central office when visiting the station. The reports of sanitary inspections (to be kept in a manila folder) may be recommended for destruction and disposed of in accordance with the approved procedure for disposal of inactive records.

(B) RESPONSIBILITY FOR CORRECTION OF INSANITARY CONDITIONS.--The sanitary inspector will instruct the head of the major division having jurisdiction as to correction of insanitary conditions. It will be the responsibility of such division head to initiate and follow through such correction. It will be the responsibility of the manager to insure that corrective action ordered by the sanitary inspector has been fully taken.

(C) SANITARY OBSERVANCE IN GENERAL.--Employees will be required to maintain careful cleanliness of floors, walls and ceilings. Continuous attention will be given to prevention of breeding of flies, roaches or ants. Appropriate measures will be taken against mosquito propagation. Screens of doors and windows will be kept in good condition. See R. & P. 6126 (D) as to sanitation of wards.

(D) SANITATION OF BARBER SHOPS.--The floors and walls of barber shops at facilities, including premises used by concessionaires, will be kept clean. Alum or any other material employed to stop the flow of blood will be used only in a powder or liquid form; the use of the common styptic pencil or of lump alum will not be allowed. All brushes, combs, razors, clippers, scissors, tweezers, and lather brushes will be thoroughly cleansed and sterilized after every separate use thereof. Sterilization of brushes and combs will be accomplished by immersion in alcohol (ethyl, denatured) of not less than 65 percent strength for ten minutes. Razors, scissors, clippers, or tweezers will be sterilized by immersion for not less than ten minutes in a 5 percent aqueous solution of phenol, or alcohol of not less than 65 percent strength, or 20 percent formaldehyde, or other method of sterilization which is equally effective. Individual clean laundered towels will be used. Head rests of barber chairs will be covered with a clean towel or clean sheet of paper. Barbers will be required to keep their hands thoroughly cleaned, with finger nails trimmed close. They will wear clean smocks, as provided in R. & P. 6013 (E). (June 30, 1944.)

## PHYSICAL EXAMINATION OF APPOINTEES AND EMPLOYEES; MEDICAL TREATMENT OF EMPLOYEES

6328. EXAMINATION OF APPOINTEES.--(A) See R. & P. Personnel, relative to the terms of the Executive Order No. 9063, February 16, 1942, and Regulations of the United States Civil Service Commission, effective March 16, 1942, issued pursuant thereto, governing "War Service Appointments", of temporary and indefinite types, and requirements as to physical examinations for such appointments.

(B) (1) The United States Civil Service Commission advises that an appointee must have no communicable disease that will create hazard for him or his fellow-employees. The communicable diseases most often recorded in medical certificates are tuberculosis, gonorrhea, syphilis, lymphogranuloma inguinale and lymphopathia venereum. Under no conditions will examinees with active tuberculosis be accepted.



The medical certificate of persons with a history of tuberculosis should contain evidence that the following standards of arrest are met: (1) constitutional symptoms absent; (2) sputum, if any, concentrated, found microscopically negative for tubercle bacilli; (3) lesions stationary and apparently healed upon X-ray examination; no evidence of cavity; (4) these conditions to have existed for six months, during the last two of which the patient has been taking one hour of walking exercise twice daily, or its equivalent. This standard applies to employment where the work is light, sedentary or moderate, and where it is not subject to unusual hazards of temperature, humidity, dusts, etc. For arduous duty positions a longer period of arrest may be required, dependent upon a history of the amount of the disease, a recommendation of a private physician or hospital physician, and opinion of the Federal examiner who reviews the case. Medical evidence will be required that gonorrhea, lymphopathia venereum and lymphogranuloma inguinale have been arrested or controlled by treatment. Persons given a diagnosis of syphilis may be appointed if there is assurance that they have had two years of adequate treatment, that their present condition is not communicable, and that they are capable of performing the duties of the position without endangering other employees. Syphilitic persons who have had inadequate treatment, but are not a hazard to themselves or fellow-employees, can be accepted, so far as physical requirements are concerned: thus an opportunity for employment is afforded, while the appointee is given medical treatment. When there is a history or evidence of mental disorder, epilepsy, diabetes, organic heart disease not fully compensated, seriously defective vision, severe crippling condition or severe hypertension, the appointing officer may consult a medical officer of the United States Civil Service Commission (central or regional office) as to acceptance of the examinee.

(2) When a history of tuberculosis is disclosed, the Civil Service Commission requires that a special Form 4434, Medical Report, Pulmonary Tuberculosis, be secured and approved before certification or appointment. When a history of tuberculosis is not disclosed until the case is processed for appointment, this special form must be executed, and approval given by either the medical officer of the employing agency or, upon request by the Commission's central office or regional office, before appointment can be made. This special form must be completed and approved, even though the regular certificate has been submitted.

(C) The terms of (B), as communicated by the Civil Service Commission, are for the general guidance of examining physicians of the Veterans Administration. Regardless of them, no prospective appointee will be accepted for assignment to food-handling duties at the facility, if affected with a venereal disease. [ ] (August 22, 1944.)

(D) (1) The Civil Service Commission does not require physical examination in appointments for one year or less ("Temporary"). However, such prospective appointees to positions in the facility will be given the physical examinations, required for the administrative purposes of the Veterans Administration, which are hereinafter defined. No charge will be made for such administrative examinations.

(2) The Civil Service Commission requires physical examination for appointments of more than one year ("Indefinite"). These are to be recorded on the Commission's Form C.S.C. 2413, medical certificate. If the examinee be accepted for employment by the Veterans Administration, that completed form will be placed in his personnel folder at the station. If he be rejected, that completed form will be

returned to the office of the regional director of the United States Civil Service Commission. For execution of Form C.S.C. 2413, medical certificate, a fee of \$2.50 will be charged to the examinee, whether accepted or rejected. Exempted from payment of this examination fee are prospective appointees to position of attendant, hospital or mess. Appointments to utility positions in grade CPC-4 and lower in positions of laborer, laundry helper, mechanic's helper, guard, etc., may be made without the requirement of a pre-employment physical examination. The appointment should be made with the understanding that if any disqualifying condition is found after appointment, the appointee will be separated for failure to meet physical requirements. Immediately after appointment a general physical survey will be made of the appointee without charge to determine whether he is free from any type of contagious or infectious condition, whether there is any disability such as hernia, hemorrhoids, etc., that might be detrimental to his work. The said general physical examination will be recorded on C.S.C. Form 2413, which will be placed in the employee's personnel file. See also R. & P. 6329 (A) for special examinations of food-handlers and personnel to be assigned to care of tuberculous patients, before they enter upon those duties.

(3) The C.S.C. Form 2413, filed in the examinee's personnel folder, will be kept indefinitely, subject to release to the United States Employees Compensation Commission, if requested for consideration of a claim for benefits.

See also R. & P. Personnel, relative to appointments (9226), examinations for tuberculosis (9670), and survey of personnel to determine their physical and mental fitness to discharge their duties (9718).

For physical examination of persons referred by other Federal Agencies, see out-patient examinations.] (July 31, 1944.)

[6329. EXAMINATION OF EMPLOYEES.--(A)(1) Besides the physical examination of all appointees, recorded on C.S.C. Form 2413 (see R. & P. 6228 (D) (2)), special examinations are required for food-handlers and employees assigned to duty with tuberculous patients.

(2) Food-handlers, comprehending hospital and mess attendants; persons engaged in dairy activities, and those handling milk, cream, butter and other foods in broken packages; nurses (except the chief nurse and operating suite nurses); dietitians, cooks, bakers, butchers, meat cutters, kitchen and dining room employees; and food-handlers employed by concessionaires will, upon assignment to those positions, receive laboratory examinations of sputum, urine and feces, and a throat smear. These examinations will be repeated whenever judged necessary by the chief medical officer or clinical director, but not oftener than every six months. An employee who is assigned to food-handling duties more than six months after acceptance for employment, will be given another general physical examination besides these laboratory tests.

(3) Male food-handlers and barbers (including those working for concessionaires) will be examined monthly for venereal disease. Female food-handlers will not be so examined, except when judged necessary, in individual cases, by the chief medical officer or clinical director. A Wassermann test of the blood will be made if syphilis be suspected from the history or physical examination. Food-handlers found to have a venereal infection will be transferred to other duties; or, if this is not feasible, they may be granted such leave as they may be entitled to, subject to determination by medical examination at the end of such leave that they are cured of the infection. If not, the facts will be reported to central office with request for instructions as to further action.



(4) Report of laboratory examinations of food-handlers will be entered on Form 2531, those of venereal examinations on Form 2533, and those of general physical examinations of food-handlers on C.S.C. Form 2413. Only one copy of any of these forms will be made, and it will be placed in the personnel file of the employee concerned, or in a separate file if the examinee is an employee of a concessionaire. The C.S.C. Form 2413 will be kept indefinitely; the previous Forms 2531 and 2533 will be removed from the personnel files when replaced by the report of a subsequent examination of the same type, and the removed forms will be recommended for destruction in accordance with approved procedure for disposition of inactive records.

(B) (1) Physicians, dentists, nurses, social workers, dietitians, occupational therapy aides, physical therapy technicians, librarians, laboratorians and attendants assigned at facilities primarily for tuberculous patients or at facilities where there is a special unit for continued care of a group of such patients will, upon appointment, be given a careful physical examination of the lungs, roentgenographic examination of the chest, and tuberculin test (Mantoux). For reactors to tuberculin, who are under age 30, roentgenograms of the chest will be repeated every six months of continuous assignment to duty with tuberculous patients; for those over age 30, roentgenograms will be repeated every twelve months; and roentgenograms will be made upon termination of such duty of persons in either of these age-groups. Also, tuberculin tests will be repeated every six months on non-reactors, but roentgenograms will not be required unless the test be positive. Should the test become positive following a prior initial or semiannual negative reaction, the lungs will be checked thoroughly by roentgenographic examination every three months for eighteen months, whereupon the routine roentgenograms (dependent upon age of the employee) will be resumed. Full use of roentgenograms of the chest will be made on all personnel presenting suggestive symptoms of tuberculosis, such as afternoon fever, excessive fatigue, loss of weight, pain in the chest and hemoptysis, who have been on duty with tuberculous patients.

(2) Reports of examination of personnel assigned to duty with tuberculous patients will be made on one copy of Form 2533, which will be placed in the employees' personnel folders, for indefinite retention. These reports, together with the C.S.C. Form 2413, record of physical examination upon acceptance for employment, are subject to release upon request of the United States Employees Compensation Commission, for consideration of claims for benefits.] (July 31, 1944.)

[6330. ASSIGNMENT OF PERSONNEL TO CARE OF TUBERCULOUS PATIENTS.--(A) The higher minimum age limit set for personnel assigned to care of tuberculous patients no longer obtains; they will be subject to the age requirements applied to other personnel. The family and personal histories of employees proposed for duty with tuberculous patients will have regard. Ward physicians will instruct nurses and attendants so assigned relative to precautions to be taken in respect to personal hygiene and sterilization of patients' sputum and utensils. Such employees will be instructed to consult their ward physicians promptly when they are not feeling well. But advice given them must be imparted in a way that will not excite unnecessary alarm or timidity. It is to be emphasized that careful observance of precautions will adequately prevent infection. These instructions are particularly indicated for personnel in charge of tuberculous psychotic patients.]

(B) Should an active tuberculous lesion be detected in an employee, he or she will be at once relieved from duty and placed under treatment, while claim will be filed with the United States Employees Compensation Commission (accompanied by certified copies of station records of physical and X-ray examinations and tuberculin tests

of the employee). At the same time, search will be made for contacts and the source of the infection.] (July 31, 1944.)

[6331. VACCINATIONS OF EMPLOYEES.--(A) Anti-smallpox vaccination will be given all employees at a facility upon initial assignment to duty, except when in the judgment of a chief medical officer or clinical director or a physician designate of either, the employee had received a satisfactory vaccination elsewhere within a sufficiently recent time. Anti-smallpox vaccination of any facility employee will be repeated when necessary in the judgment of any of the officers mentioned.

(B) Anti-typhoid vaccination (plus paratyphoid A and B, if obtainable) will be given every employee upon initial assignment to duty as a food-handler, except when there is sufficient evidence, in the opinion of a chief medical officer, clinical director or designate of either, that protective vaccination of this sort had been given within a sufficiently recent time. Anti-typhoid (with paratyphoid A and B, if available) will be repeated when judged necessary. Employees of concessionaires will be subject to these vaccinations given food-handlers, as well as the anti-smallpox vaccination.

(C) Form 2534 will be used to record protective vaccinations, and these records will be retained indefinitely in the personnel folders of the employees concerned, except that they may be removed and recommended for destruction in accordance with the approved procedure for disposition of inactive records, when replaced by a report of a subsequent vaccination of the same type.] (July 31, 1944.)

[6332. MEDICAL TREATMENT OF EMPLOYEES.--(A) An employee of the Veterans Administration may be provided treatment, hospital or out-patient, as (1) an employee per se; as (2) an employee eligible for hospitalization as an ex-member of the armed forces; or as (3) a potential beneficiary or authorized beneficiary of the United States Employees Compensation Commission. When, therefore, an employee becomes ill or is injured, it is necessary that the facility physician who attends disabled personnel shall make a preliminary decision whether the injury of an applicant for treatment was or was not received in performance of duty, for that decision will determine the status of the patient.

(B) If it be decided that the employee's injury was received in performance of duty, his treatment will be begun as a potential beneficiary of the said Commission, and he will be identified as such in reports to central office. See also R. & P. 6022, hospitalization of beneficiaries of the United States Employees Compensation Commission. Physicians attending disabled personnel will familiarize themselves with the "Regulations Governing the Administration of the United States Employees Compensation Act, as amended", copies of which are obtainable from the Commission; and with R. & P. 9408, relative to preparation and submittal of forms to the Commission. It is to be understood that the Commission will accept billing for treatment of a potential beneficiary up to the date of disallowance of a claim filed by him. Notice of disallowance of such claim will be supplied the manager of the station; and, from the date of the disallowance the expense of any continued hospitalization will be chargeable to the employee (unless his entitlement to hospital treatment as an ex-member of the armed forces is exercised), at the current reciprocal Government hospital per diem rate, plus "extra services" as defined. If the Commission accepts his claim, the Veterans Administration will be asked to provide such continued hospitalization as he needs, as a beneficiary of the Commission. The per diem reciprocal Government hospital rate that is current will be charged the Commission. For out-patient treatment of its beneficiaries, the Commission will be



charged \$1.00 a treatment, to include dressings and ordinary medicines. Monthly reports on Form 1086 will be forwarded to the director of finance up to the termination of treatment, specified as hospital or out-patient, of a beneficiary of the United States Employees Compensation Commission.

(C) If it be decided that the condition of the ill or injured employee is not attributable to performance of duty, the only authority for rendering him out-patient treatment is that provided in R. & P. 9661, which empowers treatment that will make it possible for him to "remain on duty, or would be in the interest of general conditions in an office." The type and duration of out-patient treatment will conform to those principles. The "minor ailments" specified in R. & P. 9661 ("colds, headache, indigestion," etc.,) may be treated to keep the employee at work, or to protect against infection of other employees (through transmission of "colds," etc.,) but such treatments of minor ailments are not to be continuous nor to be given over an extended period of time. An average duration of 48 hours of such treatment will sufficiently meet the indications, viz., to relieve pain and discomfort, prevent infection, and allow resumption of his duties by the ill employee. Should treatment beyond this be required, the ill employee will be instructed to procure it from a private physician or dentist, as the case may be. However, if such private professional service is not feasibly available, because of the comparative isolation of the field station, the further out-patient treatment required may be supplied at the station, subject to a charge of \$1.00 for each treatment. No charge will be made for the 48-hour period.

(D) If the illness of an employee demands hospitalization and, perhaps, surgical intervention, hospitalization can be furnished and continued until the emergency is ended, and discharge of the patient can safely be made. Should, at that time, there be need of further out-patient treatment in the case, the employee will be instructed to procure the needed continuance of treatment through a private physician; but if this is not feasibly available, because of comparative isolation of the station, such employee may be supplied continuance of needed out-patient treatment, at charges provided in (C).

(E) Fees for medical treatment chargeable to an employee will be billed and collected at the station where he is employed, with this procedure obtaining; the personnel officer will ascertain from the chief medical officer, clinical director or designate of either, the items of medical service (hospital or out-patient treatment or both, duration of hospitalization, or number of out-patient visits, with total expense), will make appropriate entries on Form 1216, Account of Sale or Collection, and forward the prepared form to the finance officer. If approved, the finance officer will transmit the form to the agent cashier, for collection from the employee and completion of the form. If any difficulty is had in collection, the facts will be reported to the director of finance. Chief medical officers, clinical directors, or their designates will not fail to notify the personnel officer of the completion of treatment of an employee, so that billing will not be delayed.

(F) If an employee is an ex-member of the armed forces and needs hospital treatment for his illness or injury, he may file Form P-10; and, if found eligible in accordance with the criteria in R. & P. R-6047 and R-6048, including determination of his inability to defray the expense of the service, he may be admitted to hospital, or continued in hospital as a beneficiary of the Veterans Administration. But Form P-10, Application for Hospital Treatment or Domiciliary Care, will not be filed

prior to the receipt of information of unfavorable adjudication of his claim by the Commission. Up to that time, the employee is to be primarily regarded as such, and not as a potentially entitled ex-member of the armed forces. That latter eligibility is suspended until the Commission has made an unfavorable adjudication of his claim, whereupon it is revived.

(G) Right to treatment of an employee, without charge, as an ex-member of the armed forces, extends only to hospitalization. Out-patient treatment can be furnished only for a disease or injury incurred or aggravated in armed service.

(H) RECORDS. - (1) Form 2534, application for treatment, will be executed for the ill or injured employee by his immediate superior or the personnel clerk, and will be filed in his personnel folder, where it will be kept one year, and then recommended for destruction in accordance with the approved procedure for disposition of inactive records.

(2) Clinical records, Form 2614 series, will be used for employees admitted for hospitalization, whether as beneficiaries of the United States Employees Compensation Commission or not. These will be stored as provided for other patients.

(3) Form 2593, record of hospital treatment, will be submitted to the budget officer and chief of statistics, as follows:

(a) If an employee, not an ex-member of the armed forces and thereby not potentially entitled to hospital treatment, and who has not filed claim with the Commission, requires hospitalization, his first (admission) Form 2593 will carry under "Class of Beneficiary" the identifying symbol "V.A. Empl." (signifying Veterans Administration employee) and that symbol will be assigned until the complete Form 2593 is submitted when he is dehospitalized.

(b) If the circumstances are the same as in (a), save that the employee has filed a claim with the Employees Compensation Commission, the first (admission) Form 2593 will carry the symbols "V.A. Empl.: ECC", signifying an employee whose claim is pending. If during such hospitalization notice is received that his claim is accepted, a supplemental Form 2593 is to be submitted, showing change of code symbol to "ECC", signifying that he is now a beneficiary of the Commission. If the notice is that his claim has been rejected, a supplemental Form 2593 will be submitted with change of symbol to "V.A. Empl."

(c) If the circumstances are as in (b) except that the employee has a potential eligibility as an ex-member of the armed forces, the first Form 2593 will identify him as "V.A. Empl.: ECC". Should he still be hospitalized when notice is received that his claim has been accepted, the supplemental Form 2593 that is to be submitted will then identify him as "ECC." a beneficiary of the Commission. Should the notice inform of disallowance of his claim, he will execute Form P-10 and, if found eligible for hospitalization, it will be continued; but the supplemental Form 2593 sent in will now read "NSC; Hosp.; R-6047" (add subparagraph (C), (D) or (E) dependent upon the provisions met by him).

(d) If an employee, not an ex-member of the armed forces, has been discharged from hospital before a claim filed with the Commission has been adjudicated, the complete Form 2593 sent in when he was dehospitalized will have continued the identification "V.A. Empl.: ECC". If the notice now received shows that the Commission has approved his claim, a corrected final Form 2593 will be submitted showing discharged "ECC". A short explanation under "Remarks", thus: "Employees Compensation Commission approved his claim after he had been discharged from hospital", will be



helpful. If, however, notice of disallowance of his claim is received after his de-hospitalization, then the definitive Form 2593 that will be submitted should identify the former hospital patient as "V.A.; Empl." A short explanation will be made under "Remarks", thus: "Claim disallowed by Employees Compensation Commission after de-hospitalization."

(e) If an employee, with potential eligibility for hospital treatment as an ex-member of the armed forces, is discharged from hospital before the Commission has adjudicated his claim, the complete Form 2593 sent in will have identified him as "V.A. Empl.: ECC". If such notice informs of disallowance of the claim by the Commission, the employee will file Form P-10; and, if found eligible for hospital treatment, the definitive Form 2593 will read "NSC; Hosp.: R-6047 (C), (D), or (E), as the case may be."

(f) Short, appropriate explanations under "Remarks" on Form 2593 will facilitate the classification by the budget officer and chief of statistics. Thus, "Claim approved by ECC after he had been discharged from hospital", or, vice versa: "Claim disapproved by ECC following hospital discharge; eligible for hospital treatment as ex-member of armed forces."

(I) All issues by pharmacists will be covered by prescription on the authorized form, not subject to refilling unless so directed. Prescriptions for laxatives, cough medicines, nasal instillations, etc., will be in amounts just sufficient for the expected duration of the treatment.] (July 31, 1944.)

【6333. MEDICAL TREATMENT OF ARMY ENLISTED MEN AND CONSCIENTIOUS OBJECTORS ASSIGNED AS ATTENDANTS AT FACILITIES.--(A) (1) Hospitalization for enlisted men of the Army assigned as attendants will be provided by the Veterans Administration only for emergency conditions. These sick soldiers will be transferred to an Army hospital as soon as this can safely be arranged.

(2) Out-patient treatment corresponding to that to which those soldiers would be entitled at an Army dispensary, will be supplied by the Veterans Administration, including physical therapy, vaccination, etc. Dental treatment will be restricted to emergency relief of pain, extractions, treatment of abscesses. Dental radiographs will be taken as indicated.

(3) Soldiers who are found to have clinical or serological evidences of venereal disease will be discontinued as attendants, and arrangements made for their replacement.

(4) Treatment of soldier-attendants will be recorded as for other employees, and copies will be furnished their commanding officers, as official records.

(5) No charge will be made for such medical or dental services.

(B) Conscientious objectors assigned by the Selective Service System to the Veterans Administration as attendants, may be supplied such medical treatment as is necessary to make it possible for these assignees to remain in the service of the Veterans Administration, including out-patient treatment or hospitalization for inter-current conditions from which restoration to health and work may be expected. The protective vaccinations required for other employees, and the special examinations given food-handlers will be applied to these employees.] (July 31, 1944.)

## FACILITY REPORTS OF MEDICAL ACTIVITIES

[6335. FORMS TO BE USED; THEIR PERIODIC SUBMITTAL.--The following reports relative to hospital activities will be rendered to central office and other offices, as provided, at the periods stated:

(A) Weekly - (1) Report of Beneficiaries under Hospital Treatment or Domiciliary Care. This report is to be closed at noon each Thursday, and forwarded to the budget officer and chief of statistics, inclosed in the special envelope, Form 4536, on which will be typed "BED REPORT". Stations west of the Mississippi River will transmit this report by air mail, to reach central office on the succeeding Monday.

(2) Weekly regular diet menu, Form 2836, to medical director at end of each month.

(B) Fortnightly - Form 3411, revised, Awaiting Hospital Admission. This report will be compiled as of the first and sixteenth of each month, and forwarded to the budget officer and chief of statistics. Transmittal from stations west of the Mississippi River will be by air mail, and from those east of the Mississippi by special delivery. These waiting lists must be maintained on a current basis, to reflect the actual contemporaneous situation. All persons whose names are listed for 90 days will be contacted to ascertain if they have arranged other hospitalization, or still desire admission to a Veterans Administration facility, and lists will be revised from such information. As a further measure to reduce waiting lists, applications may be referred to other suitable facilities, having available beds, which are allocated under Bulletin No. 24, "Allocation of Government Facilities". The names of applicants requiring emergency hospitalization and those needing hospital treatment for a service-connected condition will not be entered on waiting lists; such applicants have preference and must be admitted.

(C) Monthly - (1) Form 2601, Report of Veterans Administration Hospitalization and Domiciliary Care. This is to be closed as of the last day of the month covered by the report, and forwarded at the earliest possible time to the budget officer and chief of statistics. Stations west of the Mississippi River will forward it by air mail and those east of the Mississippi by regular mail.

(2) Form 2587, Report of Dental Operators, to budget officer and chief of statistics, not later than the tenth of the month.

(3) Form 2587-A, Report of Dental Clinics, to be submitted to the budget officer and chief of statistics, not later than the tenth of the month.

(4) Form 2634, Report of Occupational Therapy, to budget officer and chief of statistics.

(5) Form 2612, Report of Physical Therapy, to budget officer and chief of statistics.

(6) Form 3408, Social Worker's Report, to budget officer and chief of statistics.

(7) Form 2620, Clinical Laboratory Report, to budget officer and chief of statistics.

(8) Form 2685, Report of X-ray and Electrocardiographic Activities, to budget officer and chief of statistics. The following instructions will guide in the preparation of this form: In Table I, no individual who is radiographed or fluoroscoped will be counted more than once. The total number of films to be entered will not include dental films. Table II represents two different items. The number of examinations or



interpretations will correspond with the number of requests for X-ray examinations (Form 2614h, Clinical Series). When two or more examinations are requested on one form, they will be counted separately (e.g., a request for radiograms of the skull and spine). But when bilateral structures, such as right and left mastoid processes, are pictured on one film, only one examination will be counted. In counting examinations or interpretations, enter numbers, for in-patients or out-patients, under each classification (e.g., chest, pulmonary; chest, cardiovascular; gastro-intestinal; gall-bladder, etc.). As to number and size of films used for each examination, it will be noted that in three places where combined or separate films might be used for the examination, provision is made for appropriate entries. Count will be made on the films of each size that are used for each examination, and the number is to be entered under appropriate size headings. When combined films are used for two purposes, the entry will be in the undivided half of the block. Multiple exposures on one film will be counted as one film and one examination. Table III is self-explanatory.

(9) Report of X-ray and Radium Therapy.--From facilities which provide these forms of therapy, there will be submitted monthly a typewritten report of the preceding month's treatments. This report, to be attached to Form 2685, Report of X-ray and Electrocardiographic Activities, will be made up as follows:

#### X-RAY RADIUM THERAPY

	Number	Number				
Description	Patients	Treatments	Surface	Needles	Implants	Intracavitary
Deep X-ray						
Superficial X-ray						
Radium						
Radon						
Bomb						

(10) Form 2816, Hospital Library Report, to medical director.

(11) Form 2818, Report of Attending Specialists, to budget officer and chief of statistics.

(12) Form 399, D.P.N.H.--Canadian and British Imperial beneficiaries remaining in a facility at the end of the month, to medical director.

(D) Quarterly - Form 2653, Report of Hospital Dietetic Department, to medical director.

(E) Annually (1) Form 2623, Confidential Efficiency Report, etc., to be prepared June 30, and forwarded to the medical director.

(2) Typed report (no form), report of medical research, projects and progress, to be prepared October 1, and forwarded to the medical director.

(F) As occasion requires: (1) Form 2633, Report of Assaults, Accidents, Elopements and Injuries etc., to medical director.

(2) Form 2623a, Experience, Qualification and Preference Statement etc., to be executed once for every full-time physician and dentist, and to be forwarded to the medical director.

(3) Form 2643, Report of Inspection of Body and Undertaking of Deceased Beneficiary Prepared for Burial or for Shipment, and Form 2822, Undertaker's Certificate, to be forwarded with case files and correspondence file in death cases.

(4) Form 2687, Inventory Report of Beneficiary's Personally-owned Effects, to director of finance, in connection with the disposition of the personally-owned effects of beneficiaries who die in or are absent without leave from facilities.

(5) Form 404, Statement Regarding Dependents of Persons Receiving Hospital Treatment, Institutional or Domiciliary Care, to central or other office, as indicated.

(6) Form 2593, Record of Hospitalization or Domiciliary Care, copy to budget officer and chief of statistics and regional office in possession of case file.

(7) Form 100, D.P.N.H., on discharge of Canadian and British Imperial pensioners, to medical director.

(8) Form 346, D.P.N.H., on admission of Canadian or British Imperial pensioner, to medical director.

(9) Whenever a beneficiary in a facility under direct and exclusive jurisdiction of the Veterans Administration dies under circumstances indicating criminal responsibility for the death on the part of a fellow beneficiary, or a facility employee, or a person not connected with the facility, the facts in connection with the apparent homicide will be reported to the civil authorities having jurisdiction. In addition, the usual report will be made to central office, on Form 2633, as provided, together with information that the civil authorities have been notified.

(G) The following are reports, plain paper, no forms, to be submitted to the medical director at the intervals prescribed:

(1) Monthly - A list of articles and repairs fabricated in occupational therapy for Government use, showing the approximate commercial cost of the material used and of the completed article or repair.

(2) Monthly - A statement showing the approximate value of services rendered by patients for whom occupational therapy projects had been prescribed, other than comprehended by (1).

(3) Annually - A statement of the year's production total, in occupational therapy, of pajamas, mattress covers, pad covers and cooks' aprons.] (July 31, 1944.)

### INTER-FACILITY TRANSFERS

[6337. TYPES OF TRANSFERS OF BENEFICIARIES.--Inter-facility transfers are of three types: (a) Those from other Federal hospitals, and from State, municipal or private hospitals, into facilities under direct and exclusive jurisdiction of the Veterans Administration; (b) those between facilities under direct and exclusive jurisdiction of the Veterans Administration; and (c) those made, in exceptional circumstances, from a facility under direct and exclusive jurisdiction of the Veterans Administration into another Federal or contract hospital.] (July 31, 1944.)

[6338. AUTHORIZATION OF TRANSFERS.--(A) (1) Transfers from other Federal and State, municipal or private hospitals into facilities under the direct and exclusive jurisdiction of the Veterans Administration are to be initiated and arranged, through chief medical officers, by managers of regional offices and facilities with a regional office, having territorial jurisdiction. Only when transfers en bloc of a relatively large group of Veterans Administration beneficiaries are involved - as in transfers from contract hospitals into additional beds made available through new construction or alteration of facilities - will the medical director's approval and direction of such transfers be required.

(2) In transfers of a considerable number of beneficiaries from a State hospital into a neuropsychiatric facility of the Veterans Administration, the manager of the regional office or facility with regional office which has charge of those



transfers, will send a physician of his station to the State hospital, to confirm the number, names and eligibility of the patients who are proposed for transfer; and to examine their physical condition, in association with a physician of the State hospital. Notations will be made of any apparent injuries to those patients, to be countersigned by the physician representing the State hospital. The Veterans Administration physician will render a report in duplicate to the manager of his station, who will retain the original and send the copy, without delay, to the manager of the neuropsychiatric facility of the Veterans Administration at which these beneficiaries are to be received. These transferred patients will again be physically examined upon their reception at the said facility to ascertain if they have received any injuries en route.

(B) (1) Transfers between facilities under direct and exclusive jurisdiction of the Veterans Administration will be initiated and arranged, through chief medical officers or clinical directors, by managers of such facilities. Besides transfers for medical treatment or domiciliary care, this includes authority to transfer patients to a diagnostic center, for advice as to diagnosis and treatment of a problem case, in the attempted solution of which the resources of the referring station have been exhausted; and transfers to a diagnostic center for observation and examination requested by adjudication officers or by central office. It also includes transfers to special treatment centers, such as to the nearest tumor clinic, chest surgery center, center for tropical diseases, center for treatment of neurosyphilis in mentally competent patients, etc. Before transfer of a patient to a tumor clinic for treatment, it must first be established that the growth is malignant, and if there is doubt of the possibility of benefit, a clear history, the clinical findings, and photographs or roentgenograms, if any, should first be sent to the clinic, with request for advice as to the proposed transfer. Before referring a patient to a chest surgery center, a full set of roentgenograms, a history and a clinical summary, will be sent to the center for advice, and the nature of the reply will govern the further action to be taken.

(2) Chief medical officers and clinical directors, because of discontinuance of the weekly report of unoccupied beds, previously furnished by central office, will assure themselves of the availability of beds in the facility or diagnostic center to which transfers are contemplated.

(3) Transfers for domiciliary care will require prior consent of the director of national homes, to be requested by submittal of Form 2649, Request for Inter-facility Transfer.

(4) Form 2557, Admission Card, forwarded to the receiving facility, will be the authorization for a transfer. Form P-10, application, upon which the beneficiary had been admitted to the transferring facility, will not be forwarded.

(C) Transfers from facilities under direct and exclusive jurisdiction of the Veterans Administration into another Federal or contract hospital, will require prior approval of the medical director, who will be fully informed of the reasons for the proposal when the request is made. The request will be by letter; Form 2649 will not be used.] (July 31, 1944.)

## GENERAL POLICY GOVERNING TRANSFERS

¶6339. ADMINISTRATIVE CONSIDERATIONS.--(A) Inter-facility transfers will be made at Government expense, only for administrative and medical reasons of validity. They will not be made, at Government expense, merely to accord with the desire of a beneficiary or his representative; and they will not be considered merely because a patient is fractious or requires unusual nursing or attendant care. They may appropriately be effectuated:] (1) When a patient is improperly hospitalized in respect to the condition needing treatment. This consideration may present when the admission had been made, in a medical emergency, to the facility nearest the patient's place of residence; had received emergency treatment; but requires continuance of treatment which can be better and more conveniently provided at another facility. (2) When a facility is not equipped for the proper treatment of a disease or injury. This consideration is closely allied to (1), but may arise when for example, a general medical or surgical patient develops a psychosis in a facility with no available accommodations for the care of the mentally disturbed; or develops a condition, such as a malignant tumor or a severe allergic disorder, requiring special therapy that is available only at certain facilities. (3) When, upon completion of hospital treatment, the patient is to be provided domiciliary care, and barracks or other accommodations for domiciled members are not available at the facility where the beneficiary is receiving hospitalization. (4) For administrative reasons, as when it is necessary to evacuate beds in a facility, wholly or partly, whether temporarily or permanently; or when transfers are made from other [Federal], State, city or private hospitals into facilities under direct and exclusive jurisdiction of the Veterans Administration for economic or other reasons; or when transfers are made, from one facility to another newly opened facility, of patients whose places of residence are in the territory of the new facility. (5) In exceptional cases, inter-facility transfers may be made for climatic reasons: [ ]

(B) [TRANSFERS NOT TO BE MADE DURING HOLIDAYS.--Holidays will comprise two seasons - Thanksgiving and Christmas. The first will cover a period of two days before and one day after Thanksgiving Day (Federal observance); the second will extend from December 23 to January 2 inclusive. During these three days in the Thanksgiving season and the ten days in the Christmas season, inter-facility transfers, either for hospital treatment or for domiciliary care, will not be made, except under the following conditions: (1) When consented to by a mentally competent beneficiary, or by the guardian or next of kin of a mentally incompetent beneficiary. (2) When necessitated because of a medically emergent condition of the beneficiary. (3) When administratively necessitated, as by temporary or permanent closure of a facility, in whole or in part.]

(C) REFUSAL OF TRANSFERS BY BENEFICIARIES OR THEIR REPRESENTATIVES.--When proposed transfers from other Federal, or State, municipal or other contract hospitals to facilities under direct and exclusive jurisdiction of the Veterans Administration are refused by beneficiaries, or their guardians or relatives, the manager of the station concerned will promptly put such beneficiaries, if competent, or otherwise their guardians or relatives, on notice that the Veterans Administration will not be responsible for expense of care and treatment beyond the date of the said notice. If the beneficiary's condition does not permit of transfer with safety, action will be postponed until he can safely be transferred. [The commanding officer of such other



Federal hospital or the superintendent of the contract hospital concerned, will be notified (in advance of the date) of that date beyond which the Veterans Administration will not be responsible for expense of hospitalization of the patient.】 (August 5, 1944.)

【6340.】 MEDICAL CONSIDERATIONS.--(A) The most fundamental consideration in a proposed inter-facility transfer is whether the beneficiary's condition will permit of the necessary travel without jeopardizing his life or recovery. When travel is determined as hazardous, or the condition is so advanced that the special treatment to be procured by transfer could not reasonably be expected to delay a fatal issue, the patient will be retained at the facility where he is under treatment, except in terminal cases, where he is to be transferred to a facility nearest the place of residence of relatives, so that he may spend his remaining days with his family and friends.

(B) Tuberculous patients, claimants or beneficiaries, may be admitted for observation to determine the existence of suspected tuberculosis, to the nearest facility. Until a definite diagnosis of active tuberculosis has been thus made, and unless the facility concerned has no available accommodation for continuance of expected prolonged treatment, transfer to another facility will not be recommended. Applicants with arrested tuberculosis will not require continuance of hospitalization; nor, usually, will those with a quiescent lesion, though these may be retained under treatment until definite arrest is reached. The tuberculous patients best fitted for transfer are those who are ambulatory, or have no serious complications, no serious involvement of both lungs, or no evidence of acutely progressive disease. Patients with a rapidly progressing disease, at any stage, early or late, with daily fever, night sweats, emaciation or uncontrollable cough, are not suitable for transfers involving a considerable journey; nor is a patient who had had a recent pulmonary hemorrhage. Those with extensive involvement of both lungs, or with serious complications such as nephritis, or tuberculosis of the intestines, urinary bladder or kidneys, will not be recommended for transfer to a distant facility, [(except terminal cases (A))].

(C) The guiding consideration in (B) may be departed from (1) in terminal discharges and (2) in transfers to chest surgery centers [ ]. When every available treatment resource has been exhausted and it is determined that the condition of a tuberculous patient is terminal, he may be transferred to the facility nearest his place of residence (or discharged to his home, if the relatives request); and, when a surgical collapse board so recommends, transfer may be made to a chest surgery center of a patient whose transfer would otherwise be interdicted under (B) hereof. However, in these exceptional circumstances, a patient who is moribund will not be transferred, and it must always be determined that such travel as is necessitated can be made without endangering the life of the patient.

(D) CLIMATIC CONSIDERATIONS.--Under hospital regimen, an early active tuberculosis will in most cases come to arrest, irrespective of the prevailing climate of the facility territory. In far-advanced processes, a hospital regimen is also more beneficial than change of climate. However, in occasional cases a patient who has faithfully cooperated, and whose condition promises ultimate recovery, may temporarily cease to improve, and change of climate may be of benefit in stimulating the reparative tendency. High elevation may be unfavorable in tuberculous or other conditions with complicating cardiac or cardio-vascular disorders. Transfers for climatic reasons will, in general, be exceptional. (August 5, 1944.)



## TRANSFERS OF PSYCHOTIC PATIENTS

### [6341. CONSENT OF GUARDIAN OR NEAREST RELATIVE; COOPERATION WITH CHIEF ATTORNEYS.--

(A) See R. & P. 6162.]

(B) When a patient in a facility under direct and exclusive jurisdiction of the Veterans Administration that is primarily for general medical and surgical or for tuberculous patients, or a member in domiciliary care, becomes psychotic and necessitates transfer to another facility adapted to treatment of his mental disorder, the procedure in R. & P. [6162] will be observed.

(C) Close cooperation with chief attorneys of the regional territories concerned is essential in all matters pertaining to psychotic beneficiaries. Consultation with them is particularly necessitated in arranging transfers from institutions to which beneficiaries have been duly committed by courts, or to institutions in which commitment is desired.

(D) [(1) THE POLICY IN TRANSFERS OF INDIVIDUAL PSYCHOTIC PATIENTS.--This will be the same as for transfers of tuberculous patients or those suffering from general medical or surgical conditions. If such psychotic patient be hospitalized in a facility under direct and exclusive jurisdiction of the Veterans Administration, he will be transferred, at Government expense, to another like facility, if there is medical or administrative reason requiring such transfer. But if he is in another Federal hospital, or State or private hospital, and he or his representative applies for his transfer therefrom to the Veterans Administration, and he is found eligible, he will be transferred to the nearest like facility of the Veterans Administration that is in the direction of his home, where there is an available bed. Transfer to any farther distance, as to a facility of the Veterans Administration that is within the territory of his home State, will not be at Government expense (except if later determined necessary for medical or administrative reason). Transfers made at the request and expense of guardians or nearest relatives may be made to any suitable facility where a bed is available.

(2) Transfer to a facility under direct and exclusive jurisdiction of the Veterans Administration of a patient who is receiving treatment in a State or private hospital, not at Government expense, for a condition not service connected, may be considered only when request therefor is received; and will be accomplished only when a bed is available after all the needs of applicants with a service-connected psychosis, or applicants with a nonservice-connected psychosis, who are not in a hospital, have been cleared. But request for such transfer on behalf of a patient who is receiving treatment in such hospital, not at Government expense, for a service-connected psychosis, will be complied with. Should it be necessary to defer such latter transfer for a time because a bed is not then available in the nearest suitable facility under direct and exclusive jurisdiction of the Veterans Administration, the continuance of treatment in the State or private hospital may be authorized at the expense of the Government, effective from the date of the authorization and not for any anterior period.]

(E) THE POLICY IN GROUP TRANSFERS OF PSYCHOTIC PATIENTS.--When new facilities primarily for neuropsychiatric patients are opened, or additional beds are ready for occupancy after alterations or additional construction at [ ] existing facilities, the admission of patients thereto will be made with due regard to this order of priority: (1) Applicants suffering from psychoses adjudicated as service connected, who are not hospitalized, and who require hospitalization. (2) Beneficiaries with service-connected disorders who are receiving treatment and care, authorized by the Veterans



Administration, in contract hospitals, and who are residents of the State in which the new facilities are located. (3) Beneficiaries with service-connected psychoses, who are residents of the State in which the new facilities are located, and who are under treatment in [Federal] hospitals outside of the said State; preference to be given those so hospitalized farthest away from their home State. (4) Patients with non-service-connected psychoses, who are residents of the State in which the new facilities are available, and who are hospitalized in [Federal] institutions outside of that State, when beds in such other [Federal] facilities are needed for the treatment of patients with service-connected psychoses. (5) Patients with nonservice-connected psychoses, residents of the State in which the new facilities are available, who are awaiting hospitalization. This procedure assures the hospitalization of beneficiaries suffering from service-connected psychoses in the States of their residence, reduces costs of contract hospitalization, and releases beds to meet local needs at the transferring facilities. While the general policy will favor transfer to facilities in their home States of psychotic beneficiaries hospitalized elsewhere, especially in regard to beneficiaries suffering from service-connected conditions, and when relatives request transfers because beneficiaries are hospitalized in States too remote to permit of visitation, nevertheless the application of this general policy will be influenced by certain considerations. The contemplated transfer of patients suffering from psychoses not attributed to military or naval service, from one to another facility under direct and exclusive jurisdiction of the Veterans Administration, will be influenced by consideration whether such transfers will release available beds for beneficiaries with service-connected psychoses who are being treated in contract hospitals or are awaiting hospitalization. And, when psychotic beneficiaries hospitalized outside of their States of residence are without immediate relatives, and there is no administrative or other pressing necessity for the action, such general policy need not be observed. (August 5, 1944.)

### TRANSFERS FOR DOMICILIARY CARE

[6342.] CONSIDERATION IN TRANSFERS FROM HOSPITAL TREATMENT TO DOMICILIARY (BARRACKS) CARE.--(A) Requests for transfers of patients receiving hospital treatment in one facility to domiciliary (barracks) care in [another] facility, made on Form 2649, will be addressed to the director of national homes. At most of the facilities under his jurisdiction, there are beds available for non-duty members, as well as for members whose physical condition permits of their assignment to duty in work details. Transfer for domiciliary (barracks) care may, therefore, be requested for a beneficiary who, while not meeting the requirements necessary for duty barracks, can be taken care of in a non-duty barracks. Under "Reasons for requesting this transfer" on Form 2649, it must be stated clearly whether the request is for (a) "Domiciliary care, duty barracks" or (b) "Domiciliary care, non-duty barracks." It should be indicated that the beneficiary meets the requirements pertaining to group (a) or (b) respectively. These requirements are as follows: (a) Domiciliary care, duty barracks - beneficiary must have sufficient disability to justify domiciliation (see R. & P. R-6047 (E)). He must require no nursing or attendant care; must be able to walk some distance from the barracks to the general mess hall, and be able to mount or descend stairs; must be able to dress himself, make his own bed, do light detail work, and must not require any special diet. (b) Domiciliary care, non-duty barracks - a beneficiary for whom non-duty care is requested must not require active medical or hospital treatment or any special diet. His condition must be such that he does not



need nursing care and can be cared for with limited domiciliary attendant care. (See also R. & P. R-6047.)

(B) The condition of a psychotic patient who is being considered for transfer to domiciliary care must be such as, in good medical judgment, will in all probability permit of his being adjusted to the requirements of such care. It is not practicable nor expected that such transferred patients shall receive that character of supervision which is provided them during hospital treatment. Except as to funds only, of those beneficiaries for whom a fiduciary has been appointed, which funds must therefore be continued to be handled through the fiduciary or with his consent by the manager, or by the manager through an institutional award, all patients, when transferred to domiciliary care, will receive in every respect the same care given other members in barracks. If such beneficiaries relapse during domiciliary care, so that they cannot meet the requirements for such care, they will revert to a hospital status, and will then be transferred from barracks to hospital of the same facility or, as necessary, be transferred back to the facility from which they had been sent for domiciliary care. The instructions on Form 2649, Request for Inter-facility Transfer, require that a medical and industrial history of the beneficiary be forwarded to the receiving facility. This is necessary to inform such facility as to the historical background of the case. There will not be incorporated therein the statement that the patient being transferred is "Incompetent and insane", since the receiving facility, not understanding that this characterization is of legal and not clinical significance, will be confused as to the fitness of the veteran for proposed domiciliary care. Such difficulties will be obviated if due explanation is made by the transferring facility; viz., that while the patient had been legally declared incompetent and insane, or during hospitalization had administratively been so designated for hospital purposes, he is now, at the time of proposed transfer, regarded as fully capable of meeting the requirements for domiciliary care. It will be evident that unless he is in that improved or fully recovered condition, he cannot properly be considered for such domiciliary care, in view of the condition that will surround such care, as set forth herein.

#### TRANSFERS NOT FOR MEDICAL REASONS

[6343. TRANSFER UPON REQUEST OF PATIENT.--(A) When an inter-facility transfer is requested by a patient or his representative, and is not necessary for medical or administrative reason, all expense of transportation, including attendant, will be borne by the applicant or representative, who will be required to pay also the entire expense of return transportation upon discharge from the facility to which he is transferred. To authorize such transfers, - which will not be initiated until it is ascertained that a bed is available in the desired facility - a Form 2557, Admission Card, will be executed and forwarded to the receiving facility. The referring facility will also submit a complete Form 2593, Record of Hospitalization, etc., showing disposition by transfer. The Form 2557 will bear the notation, "Transfer at personal request; return transportation upon discharge to be at patient's expense". That notation, to be placed under "Remarks", lower half of Form 2557, will have careful attention at the receiving facility.

(B) Requests for reduced railroad fares can be supplied these patients.] (August 5, 1944.)



## PROCEDURE IN TRANSFERS

[6344. ARRANGEMENTS AT THE REFERRING FACILITY.--(A) The manager of the receiving facility will be notified of the expected date and hour and railroad station of the expected arrival of the transferred patient. This notice will be sent by mail if possible, to arrive at least 24 hours before the patient; but if the circumstances require, a radiogram or telegram may be used. The word "ambulant" will be avoided in telegrams or radiograms, as it may be garbled into "ambulance"; specific wording, "Meet with Car", or "Meet with Ambulance" should be employed, as determined appropriate.

(B) The chief medical officer or clinical director or designate of either will appoint the attendant, if one is to be used; and will supervise the collection of the records which are to accompany the transferred patient. These will include Form 2557, Admission Card; Patient's Effects Slip, Form 2270, prepared as in R. & P. 9019; the form giving the recapitulation of clothing and personal effects forwarded (R. & P. 9039 (C)); a short summary of history, findings, diagnosis and treatment; Form 1170, Designation of Person to Receive Personal Effects; and X-ray films or biopsy slides, if needed. If the patient is being transferred before assignment of a C-number, the receiving station will be so informed; and told further that replies to Forms 505 or the 3101 series (if asked for by the referring station) will be forwarded as soon as received. If the transfer is for surgical operation, the written consent of the patient will be forwarded, for filing at the receiving facility. Since food-rationing regulations require that the patient's ration books be deposited, they will be sent with him, for return to him upon his discharge from the receiving facility.

(C) All clothing, valuables, miscellanies and luggage belonging to the patient will be collected and delivered to him, or his representative, or attendant accompanying him. Permission will be accorded for his taking away of any Government-supplied clothing and prosthetic or orthopedic appliance. The luggage will be searched for any Government property or contraband articles which, if found, will be confiscated.

(D) Any medicines or supplies necessary for the journey will be supplied the patient or his attendant.

(E) If the patient is a potential beneficiary of the United States Employees Compensation Commission, and claim has been filed with the Commission, but notice of allowance or disallowance has not been communicated, the facility to which the beneficiary was transferred will be so informed, and advised that the result of the adjudication by the Commission will be relayed when received.

(F) In proposed transfers to the National Leprosarium, Carville, Louisiana, a block of biopsy tissue (for preparation and staining to confirm the diagnosis) and a recommendation for the proposed transfer, will be forwarded to the Director, National Institute of Health, Bethesda, Maryland. If the diagnosis be confirmed there, the Surgeon General, United States Public Health Service, will arrange the examination of the patient at the Veterans Administration facility where he is hospitalized, and will effect his transfer to Carville, at expense of the United States Public Health Service.] (August 5, 1944.)

## TRAVEL PRECAUTIONS

[6345. (A)] GENERAL MEDICAL AND SURGICAL PATIENTS.--When Pullman or equivalent accommodation is available, the travel of general medical or surgical patients may be authorized in berths or, for stretcher cases, in compartment or drawing room, if



judged essential. However, day coach transportation may be authorized, either when Pullman accommodation is not available or when it is judged not necessary, as in ambulant cases, especially those without accompanying attendants. [ ]

[(B)] Psychotic patients will ordinarily be transported in compartments or drawing rooms of Pullman cars, and not in berths of such cars, except that where no Pullman service is available for the part or all of the projected distance of transfer, then day coach transportation may be used, provided that especially adequate attendance is supplied and the patient is not noisy or actively disturbed. Transfer of psychotic patients in automobiles, preferably closed cars, will be considered for approval, upon recommendation of managers, especially for relatively short distances, or when satisfactory Pullman transportation is not available. When transfer en bloc of a sufficient number of psychotic patients is proposed, the charter of a Pullman car will be arranged, with a properly proportioned number of attendants. When the travel distance involved and the railroad schedule permits, transfers of psychotic patients will be made, as far as possible, during their waking hours, that is, between a reasonable hour in the morning and a reasonable retiring hour at night. Transportation of disturbed psychotic patients in buses will not ordinarily be proposed, but may be approved, upon recommendation, when other means of travel are not available. Especial care must be exercised in assigning attendants having the necessary qualifications as to experience and personal character to accompany psychotic patients who are being transferred.

[(C)] TUBERCULOUS PATIENTS.--Transfers of actively tuberculous patients will be made in full compliance with the provisions of the Interstate Quarantine Regulations of the United States. These are:

Common carriers, their agents or employees, shall not receive for interstate transportation any person known by them to be afflicted with pulmonary tuberculosis in a communicable stage unless said person is provided with (a) a sputum cup made of impervious material and so constructed as to admit of being tightly closed when not in use; (b) a sufficient supply of gauze, papers, or similar articles of the proper size to cover the mouth and nose while coughing or sneezing; (c) a heavy paper bag or other tight container for receiving the soiled gauze, papers, or similar articles; and unless such person shall obligate himself to use the articles provided for in the manner intended and to destroy said articles by burning, to disinfect them by immersing for at least one hour in a 6 percent solution of carbolio acid or other solution of equivalent disinfecting value in a covered vessel.

A tuberculous patient, before he departs from the facility, will be supplied the necessary articles to be used en route, and cautioned to observe these precautions; and, if he is accompanied by an attendant, the latter will be instructed to secure full compliance on the part of the patient. (August 5, 1944.)

#### DIRECT TRANSFERS FROM ARMY AND NAVY HOSPITALS INTO VETERANS ADMINISTRATION FACILITIES

[6346. (A) ARMY.--(1) When an officer, including a nurse, dietitian or aide (physical therapy or occupational therapy) or officer of the Women's Army Corps, or an enlisted soldier (including enlisted personnel of the Women's Army Corps), about to be discharged for disability, is at that time in need of continued medical treatment, he will be referred to the Veterans Administration. The registrar of the Army hospital concerned requests the medical director to designate a facility of the Veterans



Administration at which the further treatment will be furnished. From the informative data incorporated in that request, the medical director selects a suitable facility, having an available bed, which is nearest the home address of the soldier. The commanding officer of the Army discharge point is authorized (Medical Form 2834 - Designation of Hospital for Patients of Armed Forces), to deliver the soldier and discharge him at the designated facility; he is informed that the reservation of the bed is void thirty days after receipt of the authorization; and he is asked to inform the manager of the designated facility of the proposed day and hour of the soldier's arrival.

(2) The soldier will be accompanied by Veterans Administration Form P-10, Application for Hospital Treatment or Domiciliary Care, fully executed and sworn to, and Veterans Administration Form 526, Application for Disability Compensation or Pension, executed if desired by the soldier. The Army records sent with him will consist of all of the clinical records which are available, together with roentgenograms and electrocardiograms, if any, which were made during his stay in the Army hospital of reference (except the final chest film, which is sent to central office, for storage); a copy of the Certificate of Disability for Discharge (WD AGO Form 40); Soldier's Qualification Card, WD AGO Form 20; and the photostat of report of physical examination upon entrance into military service (this last exhibit may later be furnished).

(3) Promptly upon receipt of these exhibits, the data in the Army clinical records, and in the photostat of report of physical examination upon entrance into military service, will be summarized rapidly and transposed to Forms 2614b and c, clinical records, prepared for the admitted patient.

(4) Then, without delay, the Army exhibits (consisting of the clinical records, the copy of the Certificate of Disability for Discharge, WD AGO 40, the Soldier's Qualification Card, WD AGO 20, and the photostat of report of physical examination upon entrance into military service); and the Veterans Administration records (consisting of Form 526, Application for Disability Compensation or Pension, Form 404, statement regarding dependents, Form 357, statement of claim for waiver of premiums, notice to chief attorney of the admission of a mentally incompetent patient, in accordance with R. & P. 5247, and the red copy of Form 2593, record of hospitalization, etc., for incorporation in the claimant's case file) will be forwarded, registered mail, to the office of the Veterans Administration which has jurisdiction over the territory shown on the WD AGO Form 40 as the mailing address of the soldier-patient. In cases of veterans discharged because of mental disease or as incompetent, examination will be completed within a few days after the veteran entered the facility and a report thereof forwarded with the material to such office. Expedition in referring these exhibits to the said office, for consideration in the adjudication of a claim for monetary benefits, is imperative. Form 2619, in duplicate, Transmittal of Service Records and Veterans Administration Forms, will be used to forward these papers to the said office of the Veterans Administration. A check mark will be placed opposite each exhibit that is enclosed. If the photostat of the report of physical examination upon entrance into military service was not sent from the Army discharge point, a check mark will be placed upon the phrase "Army records not inclosed will be forwarded upon receipt". The forwarding of that photostat from the Army discharge point will not be awaited; when it is later received, it will be forwarded to the Veterans Administration office aforesaid. The duplicate Form 2619 will be signed and



returned to the referring facility as a receipt of the records at the office of jurisdiction.

(5) If a completed Form 526 had not been received from the Army discharge point, the patient, if mentally competent, will be asked if he desires to file a claim for pension. If he so states, he will be assisted in the execution of an Application for Disability Compensation or Pension, Form 526, which will also be forwarded with other exhibits to the said office of jurisdiction. If the patient be mentally incompetent, or physically unable to execute the Form 526, the manager or a contact representative (or some other designate of the manager, if a contact representative is not available) will prepare and forward a Form 526 on behalf of such patient.

(6) Form P-10, Application for Hospital Treatment or Domiciliary Care, will be retained at the facility admitting the patient, and will be filed as provided in R. & P. 6036 (E) (1), together with the duplicate of Form 2834, Designation of Hospital for Patients of the Armed Forces, which had been supplied by the medical director. Such roentgenograms and electrocardiograms as had been supplied from the Army discharge point will also be retained. An interpretation of the roentgenograms (if not already recorded in the Army clinical records) will be entered upon Form 2614h, clinical records, and the Army films will be stored with other X-ray films at the station, after identification as a Veterans Administration film in the usual manner. Since these roentgenograms coming from the Army field stations should be reasonably recent (the date of their exposure will likely be shown in the Army clinical records), the necessity of routine roentgenography at the time of admission of these patients may largely be obviated. Apart from the economy that may so be realized, the comparison of these Army X-ray pictures with films taken later at the facility will serve to indicate the relative progress of disease process, notably pulmonary tuberculosis. The Army electrocardiograms will similarly be interpreted, and the interpretations recorded on Form 2614q, report of electrocardiogram, identified as an Army exhibit. The electrocardiographic tracings will be stapled to Form 2614q.

(7) Transportation of soldier-patients from Army discharge points to the designated facilities of the Veterans Administration, including an attendant or attendants as assigned, will be supplied by the War Department. But transportation, including necessary meals and lodging, required to return such patients to their places of residence will be furnished by the Veterans Administration, provided such patients have completed all required treatment, are given a regular discharge, and (if they had been hospitalized for a nonservice-connected condition) they had stated upon their Form P-10 that they could not defray the expense of the return transportation.

(8) Attendants accompanying a soldier-patient to a designated Veterans Administration facility, who proffer Form 464, WD, QMC, requests for meal and lodging, will be supplied either or both, at a charge of \$1.00 for lodging, and 50 cents for single meals or \$1.00 for a day's ration. Form 1216 will not be executed, but the charges will be entered on Finance Form 1086, to be submitted to the director of finance, accompanied by the Form 464, WD, QMC. The director of finance will bill the Meal Ticket Section, Finance Office, United States Army, Chicago.

(9) The expense of any telegrams or telephone messages sent en route to the designated facility by an Army attendant of a soldier-patient, notifying of arrival time, etc., or sent by such attendant to the Army discharge point, notifying of his delivery of the patient, will not be defrayed by the Veterans Administration.

(Paragraph 6346 continued.)

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(10) When the medical director decides upon the transfer of a disabled female ex-member of the Army directly to a contract hospital, instead of a facility under direct and exclusive jurisdiction of the Veterans Administration, he will ask the manager of that regional office or facility with regional office which has territorial jurisdiction over the home address of the beneficiary concerned, to designate such hospital, suitable for the treatment of the beneficiary. Upon receipt of the manager's reply, the registrar of the Army discharge hospital will be authorized to deliver the patient at the designated hospital; and to send the Army exhibits (Form P-10, Form 526, Army Clinical Records, WD AGO Form 40, WD AGO Form 20, photostat of report of physical examination upon entrance into military service), to the said manager who will channel them for adjudication of the claim for pension, and will supply the contract hospital a medical summary, prepared by the chief medical officer. When any such patient is psychotic, and the manager determines that commitment is necessary, the facts will be reported to the chief attorney, as provided in R. & P. 5224, for necessary attention and authorization of court costs as therein provided.

(11) When the medical director decides to authorize the admission of a soldier about to be discharged by the Army, directly into a hospital of the Indian Service, he will communicate with the Indian Agency at which the soldier alleges he was enrolled. This is necessary because the appropriated funds can be used only for enrollees. If it is found that the soldier is an enrollee of his Indian Agency and therefor eligible, the medical director, upon being so informed, will communicate this information to the Superintendent of that Indian Hospital where it is desired to send the Indian soldier for treatment following his discharge from the Army. The superintendent consenting, the commanding officer of the Army discharge point concerned will be asked to deliver the soldier at the Indian Hospital selected, with transportation at Army expense.

(B) NAVY.--The direct reference of an officer or enlisted man, or female personnel, including the Women's Reserve of the Navy, about to be discharged upon recommendation of a board of medical survey, to a facility of the Veterans Administration designated by the medical director, will be conducted in general according to the procedure prescribed in (A) for soldiers, with these differences:

(1) The records that will accompany the naval patient will consist of Veterans Administration Form P-10, Application for Hospital Treatment or Domiciliary Care; executed Veterans Administration Form 526, Application for Disability Compensation or Pension, or a statement that the patient did not desire to file such application; and these Navy forms - Navy personnel qualification card; a typewritten or photostatic copy of the descriptive sheet in his health record (NMS Form H-2); a typewritten (carbon) copy of his medical record; a copy of the report of the board of medical survey (NMS Form M); and a statement showing the type of discharge issued, whether honorable or otherwise. After summary and transposition of the medical data in these records to Forms 2614b and c, clinical records, for use on the facility ward to which the naval patient is admitted, these naval records (except Form P-10) will be relayed without delay to the office having jurisdiction over the territory of the home address of the patient, together with the Veterans Administration forms and medical examination report in cases of veterans discharged because of mental disease or as incompetent specified in (A)(4).

(2) X-ray films exposed during the treatment of the patient in the naval hospital will not be forwarded with the other exhibits specified, but they may be



obtained, if desired, upon application by the manager of the facility of the Veterans Administration at which the patient was received, to the commanding officer of the naval hospital from which the patient was transferred. As soon as study of such films has been concluded, the films will be returned to the said commanding officer.

(C) MARINE CORPS.—The procedure surrounding the direct admission of a disabled officer or enlisted man of the United States Marine Corps, and including the Women's Reserve of the Marine Corps, into a designated facility of the Veterans Administration from a naval hospital, will conform to that prescribed in (B).

(D) Officers or enlisted personnel of the Coast Guard (including its Women Reserve), not members of the Regular Establishment, about to be discharged for disability, may be referred directly to a designated facility of the Veterans Administration, subject to the general procedure outlined in (A), with these differences:

(1) A board of medical survey of the Coast Guard (convened at a Marine Hospital) will recommend the transfer to a facility of the Veterans Administration. The report of the board is to be approved by the Commandant, Coast Guard, Washington, D. C. The board forwards to him, in triplicate, with their report, a request for designation of a facility by the Veterans Administration. The Commandant asks the medical director to make that designation. The medical director replies to the Commandant who, in approving the board's recommendation for discharge, will so inform the District Coast Guard Officer or commanding officer of units operating directly under the Commandant, and will further advise such field officer regarding the facility designated by the medical director for the reception of the patient. Such field officer of the Coast Guard will thereupon issue travel orders for the patient and attendant, if the latter be necessary, all transportation to be charged against the travel allotment of the said district or independent unit of the Coast Guard.

(2) Disabled Coast Guard personnel so referred to designated facilities of the Veterans Administration will be accompanied by these records:

(A) Completed application for Hospital Treatment or Domiciliary Care. (V. A. Form P-10.)

(B) Completed application for Disability Compensation or Pension (V. A. Form 526); or a statement showing that the patient does not desire to submit an application for pension.

(C) A typewritten or photostatic copy of the descriptive sheet in his health record. (NCG 2525B.)

(D) A typewritten (carbon) copy of his medical record.

(E) A copy of the report of the board of medical survey.

(F) A statement showing the type of discharge to be issued, whether honorable or otherwise.] (August 5, 1944.)

## DISCHARGES FROM HOSPITALIZATION

[6349.] CLASSES OF DISCHARGES FROM HOSPITALIZATION.—(A) These are denominated as regular or irregular. Regular discharges are to be given for and designated respectively as: (1) maximum benefit attained; (2) terminal; (3) under section 202 (3), World War Veterans' Act, 1924, as amended, [as revived by section 28, Public No. 141, 73d Congress]; (4) observation completed; (5) treatment completed; (6) no treatment required. Irregular discharges are to be given for and designated respectively as: (a) against medical advice (including refusal [or obstruction of observation and



examination or refusal of treatment); (b) absence without official leave; and (c) disorderly conduct. See discipline of hospital patients.]

(B) Discharge "maximum benefit" will be given patients, who, after utilization of all available therapy resources, have attained maximum improvement, but in whom some residual disability persists that cannot be further benefited. This discharge is also in order for tuberculous patients discharged under R. & P. R-6065 (C). When a patient is determined as needing no treatment for the disease for which he was hospitalized, nor for any other discovered condition, he will be discharged "no treatment required". Patients receiving "treatment completed" discharges will include those who have been given the full therapy indicated or authorized, thereby permitting of appropriate notations "cured", "improved", etc., in the column "Result of Treatment", on Form 2593. Discharges "treatment completed" will thus be differentiated from "maximum benefit". Terminal discharges will be given those patients who cannot be benefited by further treatment, who are approaching death, and who are being sent to their homes to spend their declining days. Discharges of tuberculous patients under section 202 (3), World War Veterans' Act, 1924, [as amended, as revived by section 28, Public No. 141, 73d Congress; will conform to the conditions specified in R. & P. R-6065 and R. & P. 6151]. (August 5, 1944.)

[6350.] AVOIDANCE OF UNNECESSARY HOSPITALIZATION.--Every proper measure will be taken to avoid delay in discharge of patients who have completed all necessary observation or treatment. As soon as possible after admission of a patient who has filed or desires to file a claim for monetary benefits, the contact representative concerned will get in touch with such patient and conduct as expeditiously as possible the adjustment of any unsettled matters relative to such claim. The discharge of a patient will not be held up pending the completion of matters related to such claims; the adjustment of any details not concluded will be handled through the office having jurisdiction of the case file. Dental relief authorized for a patient must be completed as far as possible before his discharge, especially in nonservice-connected cases. When Government clothing is to be furnished an eligible patient at the time of his discharge, the need therefor must have been determined sufficiently in advance to permit of procurement thereof, so that discharge will not be delayed. (August 5, 1944.)

[6351.] ACTION WHEN PATIENT REFUSES DISCHARGE.--When a patient, ready for discharge and notified that he is to be discharged from a facility, refuses it, he will be permitted to discuss his reasons for refusal with the manager and chief medical officer or the clinical director in conference. If the reason advanced by the patient is not considered valid, and it is clear that there is no medical reason for continuance of treatment, the manager will inform the patient that discharge will be proceeded with promptly, and that, if resistance continues, it will be necessary to eject him. If his removal is made necessary, it will be effected by a guard or guards of the facility, without using unnecessary force. In aggravated circumstances, when judged necessary by the manager, the procedure set forth in R. & P. 5583 and 5584 may be followed. (August 5, 1944.)

#### PROCEDURE IN EFFECTING DISCHARGES OF PATIENTS

[6352. GENERAL PROCEDURE IN ALL DISCHARGES FROM HOSPITAL TREATMENT.--(A) Ward physicians will arrange the personal appearance at staff conferences of patients scheduled for discharge. No week days will be set apart as discharge days but,



instead, discharges will be made any day they are in order. In exceptional circumstances, patients may be discharged other than through a staff conference, upon recommendation by ward physicians, approved by the chief medical officer or clinical director. Either such officer will set the time for staff discharge conferences. The ward physician of the patient to be discharged will complete the patient's clinical records, including the lower two-thirds of the front and the reverse of Form 2614a, brief, and will transmit those records to the chief medical officer or clinical director not later than 10 a.m. the day of discharge. The chief medical officer or clinical director will carefully examine them and assure himself that they are properly prepared, and that the diagnoses, etc., are properly supported and conform to the nomenclature prescribed by the Veterans Administration. Records which are not satisfactory will be returned to the ward physician for correction, with a statement of the deficiencies. When the records are complete and properly prepared the chief medical officer or clinical director will so indicate by writing the date and "approved", followed by his initials on the lower left hand margin.

(B) The ward physician of the patient concerned will present the case to the discharge conference for discussion and review. The patient, who will not be present during that proceeding, will then be presented, and may be encouraged to ask questions relative to his condition and its subsequent treatment. While the attendance of all physicians of the staff is desirable whenever possible, the members of a discharge conference may consist of not less than three, including the chief medical officer or clinical director, or a designate of either (such as a chief of service) as chairman; the ward physician of the patient; and a physician of the staff, acting as secretary. The attendance of a social worker, while not obligatory, is advisable, especially at facilities for psychotic or tuberculous patients.

(C) If it be decided at the conference that his further treatment is indicated, the patient will be so informed and encouraged to remain in the facility. That decision will be recorded by the patient's ward physician, on Form 2614j. If the patient refuses further hospitalization, discharge against medical advice will be given.】

(D) When the staff conference recommends discharge of a patient from a facility, he will be returned to his ward, where the ward physician will give him or the hospital attendant accompanying him, a clearance slip for Government property, and will direct him to the transportation clerk, who will make any necessary facility bus arrangements, and supply transportation and meal and lodging requests for return travel from the facility, when the patient is entitled thereto. Meanwhile, delivery of money, valuables and personal effects turned over by him for custody, on admission, will be made, but not until the personal effects have been inspected in the presence of the patient or his representative, receipts obtained, and the clearance slip brought by the patient from the ward is noted and taken from him. If the wearing or taking away of Government-issued clothing has been permitted, the written authority of the manager therefor will be noted before the patient is allowed to depart. Library books will also be cleared. Transportation will not be issued until clearance is complete. After delivery to them of transportation and meals and lodging requests, as required, patients will not be permitted to return to wards, but will leave the station at once or await the departure of the facility bus in the admitting office of the facility.

(E) [When], in proper medical judgment, indicated medicines and supplies (e.g., insulin for a diabetic patient) are necessary for use by the patient during the time



estimated to cover his return travel to the point from which he proceeded to the facility, a sufficiency only of such medicines and supplies as will meet these conditions may be furnished him or his attendant, if any.

[(F) Form 2833, secretary's minutes, will be used to record the proceedings of staff meetings, including discharge conferences. Instructions for its storage and disposition are given on that form.] (August 8, 1944.)

[6353.] DEPORTATION OF PATIENTS.--When the manager of a regional office or facility is informed that the deportation of a hospitalized patient is purposed by the United States Department of Labor, he will promptly so advise the medical director, [ ] supplying the full name, C-number, register number, and home address of the patient; the diagnosis of his condition; and the proposed date of discharge of the patient to the representative of the Department of Labor, if already arranged, so that central office may take any action indicated. (August 8, 1944.)

### [TRANSPORTATION IN FACILITY TRANSFERS AND DISCHARGES

6355. (A) INTER-FACILITY TRANSFERS.--See R. & P. R-6100 (C) and R. & P. 6071, Round-trip Requests. (1) Transportation (one-way) to effect inter-facility transfers made for administrative or medical reasons may be supplied at Government expense, provided that if the patient has an uncleared disciplinary offense he will be required to execute an affidavit of inability to pay the expense; and that affidavit will be sent with him to the receiving facility where it will be put in his correspondence file, for consideration when he is to be discharged. Round-trip transportation will be supplied persons who are being referred to diagnostic centers.

(2) When a patient is transferred from one facility to another for special service (e.g., to a tumor clinic, or chest surgery center, or fitting of an appliance, etc.,) with request and expectation that, upon completion of such special service, the patient will be returned to the facility from which he was transferred, round-trip transportation will be supplied in effecting the transfer. But if the return of the transferred patient to the referring facility is not requested, one-way transportation will be supplied; and, when the special service is completed and a regular discharge is made from the facility at which it had been rendered, the patient can be furnished transportation for return to the point whence he had proceeded in traveling to the facility at which he had been originally admitted, and from which he had been transferred. This same action can be taken, despite a request that he be returned to the facility from which he had been transferred, if it is decided at the facility to which he had been sent that, the special service being completed and a regular discharge in order, he needs no further treatment of any kind. In such cases, the facility which had transferred the patient will be notified of the action, so that it may submit a Form 2593, record of hospital treatment, showing disposition "Transferred to facility at \_\_\_\_\_, for special service (specified); discharged from that facility". The facility that discharges the transferred patient to the point whence he had proceeded to the facility of his original admission, will submit a Form 2593 showing disposition by "Discharge, following transfer, for special treatment, from facility (named)". The return part of the round-trip ticket that had been supplied by the transferring facility will be surrendered by the patient, for reimbursement by the carrier company; and a new transportation request will be supplied for his travel to the point from which he had proceeded to the facility where he had been first admitted.

(3) Transportation (one-way) to accomplish transfer of a beneficiary from another Federal, State or civilian hospital to a facility under direct and exclusive jurisdiction of the Veterans Administration, will be supplied by the regional office or facility with regional office that arranges the transfer. This is a true inter-facility transfer. But when the treatment of the patient in a State or civilian hospital had not been as an authorized beneficiary of the Veterans Administration (that is, when he had been a public charge or that treatment had been at his expense or that of his relatives), an application, Form P-10, will be required to be forwarded to the nearest suitable facility of the Veterans Administration where eligibility will be determined. If the determination be favorable, transportation to cover travel to the facility can be supplied, if it is stated on the Form P-10 that the applicant cannot pay the expense of the travel. This is a true admission.

(4) Direct transfers from an Army or Navy hospital to a facility under direct and exclusive jurisdiction of the Veterans Administration will not be at the expense of the latter.

(5) When in a transfer between two facilities, it becomes necessary to rest the patient at a third, intermediate facility (as in a long stop-over for a connecting train, or some traffic delay), the said intermediate facility will effect admission of the patient for the required time before resumption of his travel, and the station car or ambulance, if necessary, can be used to transport the patient from and to the railroad station. That facility will reflect the circumstances by a Form 2593, upon which, opposite "remarks" will be entered "Stop-over between trains". The patient and attendant (if not in Government employ) can be supplied meals and lodging, as required; but an employee-attendant will not be supplied meals and lodging, without charge, if in receipt of per diem allowance in lieu of subsistence. No Form 2557 need be executed.

(6) Transfers for domiciliary care require prior consent of the director of national homes, with request submitted by Form 2649.

(B) DISCHARGES.--(1) Upon completion of treatment and regular discharge from hospital treatment, a patient will be entitled to transportation covering return to the point from which he proceeded upon admission, except when, in his application Form P-10, a patient hospitalized for a condition not service connected has stated that he can pay the expense of such travel. No return transportation will be supplied a patient who is receiving an irregular discharge, unless he has (if hospitalized for a service-connected condition) made affidavit of inability to defray its expense; or (if hospitalized for a nonservice-connected condition), he has sworn on his Form P-10 that he could not defray transportation expenses, and his economic status has not changed during hospitalization.

(2) A patient transferred directly from an Army or Navy hospital, at the expense of the Army or Navy respectively, may be supplied return transportation, upon regular discharge, to his place of residence as shown by the service records which accompanied him upon his transfer; Provided, That, in hospitalization for a nonservice-connected condition, the applicant had stated, on his Form P-10, that he could not pay the expense of transportation from the facility.

(3) Return travel from a facility, upon regular discharge, may be supplied to a point other than that from which the patient had proceeded upon admission, provided no greater expense is incurred.



(4) Return transportation can be supplied a claimant or beneficiary hospitalized for observation and examination only if the service is satisfactorily completed and regular discharge is made.

(5) The medical director may authorize return transportation to his actual home of a patient in a terminal condition, even if the distance thereto is greater than that to the point from which he had proceeded upon his admission. The Administrator, in his discretion and upon his written order, may authorize transportation for travel to a point other than that from which a patient had proceeded to a facility.

(6) Return travel from domiciliary care can be provided only upon approval of the director of national homes.

(7) When a member transferred from barracks to the hospital of the same facility has completed hospital treatment, he will be transferred back to domiciliary care if his eligibility therefor continues. If that eligibility no longer continues, return transportation to the place whence he had proceeded can be supplied if he receives a regular hospital discharge, and has stated on his Form P-10, upon admission, that he cannot defray the expense of transportation.

(8) For mileage allowance in hospital discharges, see R. & P. 6074 (B)(4).] (August 12, 1944.)

### CRITICAL ILLNESS OF PATIENTS

[6358. LETTER TO RELATIVE IN CRITICAL ILLNESS OF A PATIENT.--See R. & P. 6206 for telegram or telephone call to be sent to the nearest relative or representative of a critically ill patient. Managers may supplement such notice with a short letter, assuring the relative or representative that the patient is receiving skillful and sympathetic care and treatment. See care of patients in a terminal condition, R. & P. 6130.] (August 12, 1944.)

[6360. WILLS AND TESTAMENTARY CAPACITY OF PATIENTS.--(A) Employees will not prepare wills for patients though, in emergency, they, in an individual capacity, may witness wills executed by patients. Patients desiring to execute wills will be advised to consult a qualified attorney. A list of such attorneys may be furnished such patients, and the attorney selected by them will be requested to visit the hospital.]

(B) In facilities under the direct and exclusive jurisdiction of the Veterans Administration, when a [critically ill patient is about to change the beneficiary in his Government insurance policy,] the ward physician or nurse in charge will record the date and time of the occurrence, and the names of the relatives or friends of the patient who were present. This will be followed by a note of the mental and physical condition of the patient before, during and after the [request for change in beneficiary.] Was he confused or delirious? Could his attention be fixed? Could he reasonably comprehend the significance of his act? These notations will be entered upon Form 2614j or k, respectively. (August 12, 1944.)

### DEATHS OF BENEFICIARIES

[6361.] DEATH CERTIFICATES.--(A) Death certificates for beneficiaries who die in facilities under direct and exclusive jurisdiction of the Veterans Administration,

executed for local health officers [or bureaus of vital statistics,] undertakers, and for adjudication of death benefits, will bear the initials of the ward physician or officer of the day, but will be signed by the chief medical officer, clinical director, or the physician serving for either, over his official title. The executed certificate must meet all State and municipal requirements. The designation of the cause of death, both primary and contributory, will be withheld until completion of an autopsy that has been authorized, or until request for autopsy has been refused.

[ (A) ] To Americanized Burial Service and to record of

(B) [(1)] A standard form of death certificate has been prepared by the Bureau of the Census, Department of Commerce, which is now being used by most States. The Social Security number of the dead person is entered on that form, as item 3 (c). When this standard form is in use by the State in which the facility of the Veterans Administration is located, care will be taken to record the Social Security number upon it, in the space allotted.

(2) The Social Security number of a patient will be ascertained and recorded, upon his admission to the facility, by the employee who fills in the upper third of Form 2614a, Clinical Record - Brief, (see R. & P. 6102 (B)), from the patient, or person who accompanied him. If it be ascertained that the patient has a Social Security number which is not remembered, the entry will be "SS No. - Yes; Not Remembered". If it is stated that he has no such number, the entry will be "None". Upon death of the patient in the facility, the physician executing the death certificate will consult Form 2614a, and transpose the data to the death certificate. No further attempt will be made by the Veterans Administration to secure the Social Security number other than as just provided, except that persons accompanying the patient, who had been interviewed upon his hospital admission, may be requested (in cases where it is stated that he has a Social Security number, but it is not remembered), to forward the information after they have returned home. If they then forward the information, it will be recorded on Form 2614a.

(3) Should other than the standard death certificate form be used, the Social Security number will be legibly and conspicuously recorded on it.

(4) Some States require, upon a death certificate, the recording of such data as age of wife of the patient, the length of time the patient had lived in the community and the length of time he had lived in the State. Clinical clerks of facilities of the Veterans Administration in such States will direct that these data be developed from the patient or person accompanying him upon admission, and be entered on Form 2614a, or upon a slip affixed to it.

(C) When a body is not to be shipped, two death certificates will be prepared, one for the undertaker to deliver to the local health officer or bureau of vital statistics, and the other to be forwarded to that office of the Veterans Administration which has jurisdiction of the adjudication of death benefits in the case. But when a body is to be shipped, two extra copies of the death certificate will be executed, one to be attached to the shipping case and the other to be given to the shipping officer for attachment to the bill of lading.]

(D) A cause of death, once determined and made of record in the autopsy report or death certificate, will not be changed, except upon authorization of the medical director. Any request from relatives or representatives of the decedent, that a change be made in the record of the cause of death, will be referred, without commitment to the person making the request, to the medical director, with a complete



report of the nature and purpose of the request for change, and with the comment and recommendation of the chief medical officer or clinical director of the facility concerned. Any such recommendation, if favoring the requested change, must be supported by convincing facts in justification of such action. The medical director will inform the director, dependents claims service, [and the director of insurance,] of the decision reached by him in such recommendations. This procedure will likewise apply when a chief medical officer or clinical director, in the interest of scientific accuracy and upon the basis of the subsequent ascertainment of material facts, initiates a recommendation for correction of a previously recorded autopsy report or death certificate. (August 12, 1944.)

[6362.] LETTER IN DEATH OF BENEFICIARIES.--(A) See R. & P. [6207 (A) and (B)] for telegram, radiogram or cablegram, as necessitated, to be sent guardians, if any, or nearest relatives, etc., upon deaths of beneficiaries in facilities. A letter of condolence will also promptly be sent in all such cases. If the death occurred in a facility under the direct and exclusive jurisdiction of the Veterans Administration, the letter will be over the signature and title of its manager. When it occurred in another Government or contract hospital in which the decedent was receiving treatment authorized by the Veterans Administration, the manager of the regional office or facility with regional office activities of the territory involved will, immediately upon notification of the death, take like action.

(B) When the telegram or radiogram had been sent to a guardian or relative resident within the continental United States, this supplemental letter of condolence will be thus composed:

Date  
Location of Station

.....  
(Name and Address)

May I express my sincere sympathy in informing you of the death of your (relationship of deceased), (John Doe), which occurred (date and hour), while he was a \*(patient in) (member of) this facility.

I trust it will be a comfort to you to know that your (relationship) received every attention during his period of \*(care) (treatment) here. You will have the further consolation of the thought that he served his country, and died honored and respected by all of us.

Very sincerely yours,

\*Delete inapplicable phrase.

(C) When the telegram, radiogram or cablegram had been sent to a relative resident in an insular possession or territory of the United States, this letter of condolence will consist of the two paragraphs specified in (B), to which a concluding paragraph will be added as follows:

"As stated in the \*(telegram) (radiogram) (cablegram) of.....  
(Date)

burial took place in.....  
(National or Facility Cemetery) (Location)

with every mark of respect. The grave will be kept in good condition. It is regretted that the Government cannot defray the expense of exhumation and shipment of the body to you, but if you purpose such action I will be pleased to give any information or other assistance in my power."

(D) The letter which, as provided in R. & P. 6207 (B) (6), is to be sent in lieu of a telegram, radiogram or cablegram when the next of kin resides in a foreign country, other than Canada, will be composed of the two paragraphs of the form letter specified in (B), with this concluding added paragraph:

"Your (relationship) was buried in.....

(National or Facility Cemetery)

at....., with full military honors. The Reverend

(Location)

.....conducted.....burial

(Name of clergyman)

(Protestant, Catholic, Jewish)

services. A representative of the Veterans Administration attended the ceremonies. The grave will be kept in good condition. It is regretted that the United States Government cannot defray the expense of disinterment and shipment of the body to you, but if you purpose such action I will be pleased to give any information or other assistance in my power."

The manager concerned will transmit this letter without delay, marked "Expedite," to the chief clerk, central office, for translation and mailing to the addressee in the foreign country. (August 12, 1944.)

#### INSPECTION OF BODIES; CERTIFICATIONS; RECEIPTS; NOTICES OF USE OF FACILITY CHAPEL OR AUDITORIUM

6363. INSPECTION OF BODIES.--(A)(1) Until further notice, the inspection of the embalming process by a representative of the medical service - regardless whether the embalming is done at the facility or at the contractor's place of business - will be discontinued.

(2) A joint inspection of the body of a beneficiary who dies in a facility under direct and exclusive jurisdiction of the Veterans Administration will, after embalming and when the body is ready for interment locally or shipment, be made by a physician or male laboratorian, and the supply officer or his designate. When the embalming was done at the facility, these inspections may separately be made; but, if the embalming was done at the place of business of the undertaker, the two employees will make a simultaneous inspection, to avoid an extra trip of a station car. The representative of the medical service will note the general condition of the body, especially in respect to bruises, visibility or defective closure of incisions, evidence of exudates, tightness of the skull cap if the brain had been removed, and satisfactory use of fillers for cavities.

(3) Inspection of bodies of beneficiaries of the Veterans Administration who die in other Federal, State, municipal or private hospitals will be made, after the undertaker's preparations, by employees of such hospitals, if arrangements can be so made. Such inspections will be made as a courtesy, and no fee therefor will be paid.

(B) CERTIFICATIONS AND RECEIPTS.--(1) The results of the joint inspection of a body will be recorded, in duplicate, on Form 2643, Report of Inspection of Body and Undertaking of Deceased Beneficiary Prepared for Burial or Shipment. The original will be given to the undertaker, for attachment to his voucher for the service. The copy will be placed in the facility correspondence file of the dead beneficiary. If either inspector notes failure of the contractor to comply with any specification



on Form 2643, his signature to that form will be withheld, and the facts will be reported to the manager, for decision.

(2) Upon completion of the preparation of the body, the contractor will be required to execute Form 2822, Undertaker's Certificate, to be filed with the station copy of Form 2643, as provided.

(3) When a body is delivered to an outside undertaker employed by a relative or guardian of the dead beneficiary, the physician in charge of the morgue or, in his absence, the officer of the day, will procure from such undertaker a signed receipt for the body, by execution of Form 2652, Receipt for Body of Deceased Patient, with the day and hour of the delivery recorded thereon, and for any personally-owned clothing of the dead beneficiary (which may be delivered by such physician or the supply officer or his representative) that, as desired by the relative or guardian, is to be used to clothe the body, by the execution of Form 2687b, Receipt for Personal Effects of Deceased Patient. Such receipts, countersigned by the employee who effects delivery, will be routed for filing as indicated at the bottom of each form. (August 12, 1944.)

(C) REPORT OF USE OF FACILITY CHAPEL OR AUDITORIUM.--When the chapel or auditorium of a facility is used for funeral ceremonies (see R. & P. 6276 (D)), a report thereof, [upon a station-mimeographed form, titled "Use of Chapel or Auditorium for a Funeral", will be filed in the concluded facility correspondence file]. The name of the dead beneficiary, his C-number if any, the date of his death, the name and address of the undertaker, whether he is the facility contractor or one employed by the relative or guardian, and the day and hour of the ceremonies, will be recorded on the form. No copy need be made for station retention. (September 12, 1945.)

FOR SHIPMENT OF BODIES, BURIALS IN FACILITY OR NATIONAL CEMETERIES, FLAGS FOR THE CASKETS, HEADSTONES FOR GRAVES, ETC., SEE R. & P., SUPPLY.

6364. MORGUE AND AMBULANCE ENTRANCE IN COMMON.--At facilities where the entrance to the morgue and the point of loading and unloading of the station ambulance are the same or in close apposition, the greatest care must be exercised, when the ambulance is bringing a patient to the hospital or taking one away, that no activity in connection with the morgue be in evidence, and that doors to the morgue be closed. Managers will exact careful and continuous observance of these instructions. A corresponding "Notice" will be prominently affixed to the inner side of the door to the morgue. (August 12, 1944.)

#### DISPOSITION OF PERSONALLY-OWNED EFFECTS OF BENEFICIARIES WHO DIE IN OR ARE ABSENT FROM FACILITIES

6366. (A) FACILITIES UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--SEE R. & P. R-4800-4813. (August 12, 1944.)

(B) FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--[SEE R. & P. 4389.] (September 12, 1945.)

#### AUTOPSIES

6368. CONSENT TO BE OBTAINED.--(A) Permission to make a post-mortem examination of a deceased veteran will be obtained on Form 2667, Authorization for Post-mortem

Examination, from the surviving husband or wife, if there is one, or if not, from the next of kin. Where there is neither surviving husband nor wife, nor next of kin, permission for the autopsy may be obtained from the nearest friend, provided such action is permissible under the law of the particular State. Where it is desired to hold an autopsy and there has been a testamentary disposition of the body, the question as to which person will be asked for permission to hold the autopsy will be referred to central office by telegram or radio. Unless a guardian or committee is one of the above-named persons, said guardian or committee will not be requested to grant permission for an autopsy, since such fiduciary's authority ceases upon the death of the ward.

(B) When request for permission to perform an autopsy is made in the telegram (see R. & P. 6207 (A)) notifying an absent relative of the death of the patient, the autopsy may be proceeded with if, in the reply wire, permission is given. The telegram giving the permission will then be placed in the clinical record of the deceased beneficiary, attached to Form 2614n, Clinical Record - Post-mortem Record.

(C) When request for permission to perform an autopsy is made to a responsible person of the kind specified in the foregoing, who is visiting the facility at or just after the death of the patient, Form 2667 will be executed and filed in the clinical record of the case, as provided in the foregoing.

(D) All autopsies will be performed by the pathologist or such other physician as is designated by the clinical director or chief medical officer. No part, organ or tissue will be removed by any other member of the staff, whether attending or resident; and all parts, organs, or tissues taken from the body will remain in possession of the Veterans Administration. (August 12, 1944.)

6369. EFFORTS TO SECURE PERMISSION FOR AUTOPSIES.--Permission for an autopsy will be solicited in cases where there is doubt as to the ante-mortem diagnosis; or where such unusual clinical or pathological findings had been disclosed during the patient's hospitalization that the post-mortem evidences would result in the securing of valuable information that could be applied to the diagnosis and treatment of other beneficiaries. Where such governing principles do not apply, that is, in cases where there is reasonable probability of the correctness of ante-mortem diagnosis, clinical and pathological, autopsies will not be solicited. The numbers of desired autopsies can be increased by sympathetic, tactful persuasion of relatives at the proper time. It should be emphasized to relatives that every care will be taken to avoid disfigurement. Often, permission for a partial autopsy can be secured when a complete autopsy is refused. (August 12, 1944.)

6370. CONDITIONS CONTROLLING PERFORMANCE OF AUTOPSIES; COOPERATION WITH UNDERTAKERS; CARE IN AUTOPSIES.--(A) The performance of an autopsy will, in all cases, be secondary to the absolute requirement that a body must be thoroughly embalmed and otherwise prepared for burial, and (where shipment is necessary) shipped promptly, after careful prior inspection as provided, so that the body will arrive at the place of interment in the best possible condition. In no circumstances will an autopsy be held if thereby the embalming or other preparation is interfered with in any way, delay in shipment is occasioned, or there is any possibility that the body, upon arrival at the place of burial, will be in an unsatisfactory condition.



(B) When, in the judgment of the undertaker, a preliminary embalming is necessary, he will be left entirely free to proceed therewith. By arrangements with him, a permitted necropsy may be made before or after the preliminary embalming. If made before, absolutely no delay must be occasioned the undertaker. Where, under the terms of a contract, the undertaker performs embalming at the facility and not at his place of business, he will be required to render that service as thoroughly and with as much regard to subsequent inspections or supplementary measures of preservation thought necessary by him, as if the embalming had been done in his establishment. Cooperation of the facility officials and the undertaker is imperative to realize the fundamental necessity of prompt shipment of a body in the best possible condition. (August 12, 1944.)

6371. PERSONNEL PARTICIPATING IN AUTOPSIES.--Personnel assigned for surgical operations and after care will not actually participate in the performance of autopsies or handling of autopsy material. In the absence of the pathologist, a competent member of the staff will be assigned to conduct post-mortem examinations and handle autopsy material. The technique of standard manuals will be followed. (August 12, 1944.)

6372. AUTOPSY MATERIAL.--(A) The histologic examination of autopsy material will be proceeded with without delay and the Post-mortem Record, Form 2614n, [filed with other clinical records of the dead beneficiary]. If a Form 2593 has been forwarded to central office and the histologic examination demands a change in diagnosis, a supplemental Form 2593 will be at once submitted. (September 12, 1945.)

(B) In ordinary cases histological examinations and interpretations thereof can be completed at the facility concerned. But, in more difficult or special cases, consultation can be had with the nearest special laboratory center (see R. & P.

6061)]. In preparing material for reference to that [center,] these instructions will be followed:

(1) The organs as removed from the body will be submerged in Kaiserling's solution No. 1 for several days. Organs of such density, such as liver, kidney, or spleen, will be incised in one plane so that the fluid can penetrate the tissue more readily. After fixation the tissues can then be placed in cans of suitable size, covered with the solution, and the lids soldered on. The can will then be boxed or crated and shipped. In the event that no suitable container is available at the hospital, the tissue may remain submerged in fluids and the unit requested to forward a suitable container. Do not make multiple incisions in organs, especially the lungs. Tissue for histological study will be taken before placing the organ in K-1 solution and fixed in 10 percent formalin.

(2) A modification of the foregoing consists of cutting slabs from the larger organs, fixing as above, then wrapping each slab in cotton thoroughly saturated with the solution; place in sealed cans, box and ship as above described.

(3) If K-1 solution is not available, ship all material in 10 percent formalin. In this case, there is no need to make separate histology.

(4) If histological diagnosis only is desired, forward in tightly corked bottles in mailing tubes, slabs of tissue not over 1 cm. in thickness, submerged in 10 percent formalin solution only. No other fixative is required. Do not be afraid to send ample material.

(5) Following the shipment of the specimen, a copy of the autopsy protocol and clinical record will be forwarded to the pathological unit. In this way a complete study is furnished and the Veterans Administration will be cooperating with the other services of the Government in furnishing complete descriptions which may be valuable for future research.

(6) Kaiserling's solution No. 1 or "K-1" consists of potassium acetate, 170 gm.; potassium nitrate, 90 gm.; formalin (commercial), 1,600 c.c., water, 1,800 c.c. The formalin should be about neutral in reaction for best results. Neutralize with sodium hydrate and test with litmus paper.

(7) The fixing solution for histologic material will consist of formalin - neutral (commercial, 10 c.c.; water 90 c.c.).

[(8) Information of the name, C-number and register number of the patient, anatomical source of the specimen, and a summary of the case history and clinical features, will accompany the material sent to a laboratory center.] (August 12, 1944.)

[6373. SHIPMENT OF AUTOPSY MATERIAL.--The laboratory centers (see R. & P. 6061) at the facilities in San Francisco, California; Hines, Illinois; Washington, D. C., and New York City have been authorized by the Postmaster General to receive mailed specimens of diseased tissue, when packed in accordance with the requirements of section 589, Postal Laws and Regulations, 1940.] (August 12, 1944.)

[6374.] EXPENSE FOR AUTOPSIES NOT TO BE INCURRED WITHOUT PRIOR APPROVAL.--Chief medical officers of regional offices or facilities with regional office will not authorize the performance of autopsies upon bodies of out-patients, when Government expense is to be incurred in any case, without prior approval from the medical director, which will be requested by radio or telegram, giving reasons for the request. Such requests will not be submitted unless, in the opinion of competent medical authority, the performance of an autopsy is warranted in the interest of a deceased claimant or his beneficiary or of the Government, and then only after the consent of a responsible relative has been obtained. (August 12, 1944.)



## OUT-PATIENT ACTIVITIES

[6450. ORGANIZATION OF OUT-PATIENT ACTIVITIES.--(A) At every regional office or facility under direct and exclusive jurisdiction of the Veterans Administration, out-patient services will be made available. In regional offices, dependent upon the volume of these activities, those may be handled by the chief medical officer or, under his general direction and supervision, by his designate. In facilities with regional offices, the chief, reception-out-patient service, under general direction and supervision of the chief medical officer, will be responsible for the conduct of those activities. In facilities with no regional office, out-patient activities, under the general direction and supervision of the clinical director, will be in charge of his designate.

(B) Such delegations of responsibility for out-patient services will be implemented by authorities essential to prompt and full discharge of the functions, including requests for the issuance of notice forms to claimants and beneficiaries relative to out-patient physical examinations and treatment including the necessary transportation, meal and lodging requests; approval of reimbursement for travel expenses or grant of mileage allowance; admission for temporary hospitalization (if required for completion of physical examination) to the facility where the out-patient examination is being made, or to another Federal facility for a diagnostic or treatment measure not available at the regional office (e.g., spinal puncture, basal metabolism rate, electrocardiogram, artificial pneumothorax or refill); and preparation of Form 1086, report to the director of finance of out-patient services referred for other Federal agencies. Other authorizing powers, specified in R. & P. 6452 for delegation to chiefs of units in regional offices and facilities with regional office, may, at stations where such units have not been approved, be appropriately delegated by the chief medical officer to the chief, reception-out-patient unit, or other officer placed in charge of out-patient unit.] (August 15, 1944.)

[6451. Duties of a chief medical officer, clinical director and chief, reception-out-patient unit, as related to out-patient activities.--See Outline of Duties and Responsibilities of Field Personnel.] (August 15, 1944.)

[6452. UNITS OF MEDICAL DIVISION IN A REGIONAL OFFICE OR FACILITY WITH REGIONAL OFFICE.--(A) Only in larger regional offices and facilities with regional office and when the volume of activities requires, the medical division may be organized into units - general medical, tuberculosis, or neuropsychiatric; or general medical and tuberculosis, or general medical and neuropsychiatric, as the workloads indicate - provided that recommendation for such units, with explanation of their need, be made to the medical director and be approved by him.

(B) The chief medical officer, while exercising general direction and supervision over them, will delegate the following responsibilities to chiefs of units which have been organized as provided in (A):

(1) To the Chief, General Medical Unit - Authorization of admission of applicants suffering from general medical or surgical diseases or injuries to allocated Federal facilities or to contract hospitals, as provided; authorization of special services for hospitalized beneficiaries when such services are not furnishable under the per diem contract rate for the hospital; general supervision of the quality of care being given beneficiaries of the Veterans Administration in hospitals other than those under direct and exclusive jurisdiction of the Veterans Administration, and



visits as needed to such other hospitals; authorization for making of physical examinations and rendering of treatment by designated or private physicians for claimants or beneficiaries suffering from general medical or surgical conditions; indorsement of vouchers for services rendered by contract hospitals, designated or private physicians and medical services rendered by contractors; prescription and fitting of and repairs to orthopedic and prosthetic appliances, eyeglasses and hearing devices, and supervision of the orthopedic workshop, if there be one in operation at the station; supervision of eye, ear, nose and throat specialists, and of laboratories, the pharmacy and any physical therapy facilities at the station. The chief of unit will also direct and supervise services rendered pensioners of nations allied with the United States in war.

(2) To the Chief, Tuberculosis Unit - The same general functions as delegated to the chief, general medical unit, as related to tuberculous claimants and beneficiaries.

(3) To the Chief, Neuropsychiatric Unit - The same general functions as delegated to the chief, general medical unit, as related to neuropsychiatric claimants and beneficiaries.] (August 15, 1944.)

**[6453]. UNIFORMS OF PERSONNEL IN REGIONAL OFFICES.**—(A) In regional offices which are a part of facilities, full-time physicians, dentists, oral hygienists, dental assistants, nurses and physical therapy aides will wear, when on duty in out-patient clinics, the uniforms prescribed for hospital wear. (See R. & P. 6005-6013 [and 6014 (C) and (D).])

(B) **SMOCKS, OPERATING GOWNS.**—Physicians, full and part-time, and dentists, engaged in the examination or treatment of beneficiaries in the regional offices, including facilities having regional office activities, will wear white smocks; as will also pharmacists and laboratorians (including technicians). Such smocks will be furnished by the Government, subject to requisition and strict accountability under R. & P., Supply. Laundering of such smocks, soiled in performance of duty, will be at Government expense.

(C) The use of operating gowns in clinics of regional offices, including facilities having regional office activities, will be governed by the provisions of R. & P. 6013 [(K)]. Operating gowns so issued, when soiled in performance of duty, will be laundered at Government expense. (August 15, 1944.)

#### REGIONAL OFFICE HOURS; ADDRESSES OF PHYSICIANS

**[6455.] EXTRA HOURS FOR OFFICES.**—Managers of regional offices and of facilities having regional office activities will exercise their own judgment as to the necessity of evening clinics. However, proper arrangements will be made to insure prompt handling in medical emergencies of beneficiaries entitled to out-patient treatment. (August 15, 1944.)

**[6456.] HOME AND TELEPHONE ADDRESSES OF PHYSICIANS.**—In all regional offices where night watchmen are on duty they will be furnished the home addresses and telephone numbers of the physicians who are to be called by the watchman in the event of an emergency during the closed hours of the regional office. (August 15, 1944.)



**[6459. OFFICERS EMPOWERED TO AUTHORIZE TRANSPORTATION IN OUT-PATIENT ACTIVITIES.-**

A chief medical officer or clinical director is empowered to authorize the furnishing of transportation and necessary meals and lodging to accomplish travel of claimants or beneficiaries to and from regional offices or facilities; and they may delegate that authority to a chief, reception-out-patient unit, or other officer placed in charge of these activities.] (August 15, 1944.)

**[6460. FURNISHING OF TRANSPORTATION IN OUT-PATIENT SERVICES.--**(A) Transportation requests, and such meal and lodging requests as may be necessary, will be supplied claimants or beneficiaries reporting for authorized out-patient physical examination or medical treatment at the nearest field station, Provided, That

(1) The claimant or beneficiary does not reside in the town or city where the examination is to be made or the treatment rendered, or in the vicinity thereof, so that the said town or city may be considered his place of residence. However, when appearance at the out-patient unit entails a fare exceeding ten cents each way, transportation by common carrier (e.g., bus) or in a bus or car of the field station (if approved) may be supplied, Provided, That such authorization to meet exceptional local conditions has been granted by the Administrator, upon recommendation of the manager of the field station concerned.

(2) The applicant is not in an uncleared disciplinary status, because of irregular discharge from hospitalization for observation and examination, or for treatment; or because he had previously refused or obstructed out-patient examination. (See R. & P. R-6100 (G).) [1. (G) See (G) 4100]

(B) For the duration of the war, common carrier transportation will be authorized, because of restrictions on gasoline and tires. But if a claimant or beneficiary who had been provided such transportation requests, travels instead in an automobile, he can be reimbursed for automobile travel, as provided in R. & P. 6073, or granted mileage allowance, as provided in R. & P. 6074, after he has surrendered the unused transportation and meals or lodging requests.

(C) The expense of transportation and any necessary meals or lodging incident to the travel will be borne by the station rendering the out-patient service, and this will include services performed upon request of another station of the Veterans Administration.

(D) No transportation will be supplied a claimant or beneficiary who is referred by the field station of jurisdiction to a designated or private physician or dentist, for examination or treatment, if the former lives in or in the vicinity of the town or city of residence of the latter. But if the required travel of such claimant or beneficiary be beyond that limitation, special transportation request, Form 3267, may be supplied to cover travel to and from the person's home, if common carrier transportation will not suffice.

(E) A chief medical officer or his designate may authorize transportation to and from the field station, for a beneficiary who has been under treatment by a designated physician for a considerable length of time without apparent benefit, and when the chief medical officer proposes examination to ascertain the condition of such beneficiary, and to decide whether treatment by the designated physician is to continue, or whether the beneficiary requires hospitalization.

(F) A chief medical officer or his designate has authority to recall beneficiaries under treatment at such intervals as he may decide proper, to determine progress and modify medication as indicated.

(C) Predetermination of mode of travel will be made only in connection with the original authorization for out-patient treatment in each case. If, as a result of the first visit, it is determined subsequent treatments are necessary, the beneficiary will be requested to state before leaving the station whether the same mode of transportation is desired for the subsequent visits. Subsequent authorizations will be made accordingly.

(D) For procedure when two or more modes of travel are necessary, see R. & P. 6070 (D). (April 3, 1945.)

(E) The general limitations with respect to payment of or reimbursement of expense for hire of an automobile, as stated in R. & P. 6073 are for appropriate application. See R. & P. 6074 for mileage allowance.

(F) It will be noted that a space is left in Form 2506 wherein will be type-written the station instructions as to what number of signed receipts for oil and gas consumed en route the traveler is to submit in a claim for reimbursement of such expense. The blank space, specifying that number, will be typed in by the field station concerned, in accordance with the number and variety of State and local taxes that are included in the purchase price of the commodities or services for which reimbursement may be claimed. (December 3, 1945.)

## TEMPORARY HOSPITALIZATION

6462. TEMPORARY HOSPITALIZATION FOR DIAGNOSIS OR TREATMENT.--(A) Chief medical officers or their designates in out-patient units which lack adequate facilities for aseptic surgery, or are not fully equipped for all diagnostic procedures, will authorize hospital admission, to their own station (if it is a center), or to the nearest allocated suitable Federal hospital, of claimants and beneficiaries requiring spinal puncture, artificial pneumothorax or refills, electrocardiographic examinations, basal metabolism tests, etc.





(B) Similarly, when an X-ray gastro-intestinal series or other laboratory procedure necessitated for a requested physical examination makes it impracticable to complete the examination in an out-patient status, the claimant or beneficiary will be admitted to hospital for the required procedure.

(C) For readmission to determine progress of a disease and to modify treatment, including diet, or for re-irradiation of a malignant process, etc., see R. & P. 6050 (C) and 6067 (B). For readmission to furnish artificial dentures, see R. & P. 6231.

(D) Artificial pneumothorax or refills in pulmonary tuberculosis not attributed to armed service will always require hospital admission, since out-patient treatment is authorized only for service-connected conditions or for adjunct treatment of an associated disorder which is determined to be aggravating the disability from a service-connected condition.

(E) (1) The temporary hospitalization necessitated under the foregoing circumstances will be effectuated in accordance with a simplified procedure. No Form P-10, Application for Hospital Treatment or Domiciliary Care, or Form 2557, Admission Card, need be executed. The only Form 2593, Record of Hospitalization or Domiciliary Care, required is the complete card showing hospital discharge. Opposite reason for disposition will be recorded: "Temp. Hosp. for (completion of out-patient examination) (artificial pneumothorax)(pneumothorax refill) (artificial dentures) (observation of progress and modification of treatment)", etc., dependent upon the type of service rendered. A hospital register number will be assigned. If the service was a part of a physical examination for disability rating, a clinical record will not be made, as the execution of Form 2545, Report of Physical Examination, will suffice. But if the temporary hospitalization was for treatment, a brief note, showing the type of treatment and the reaction of the patient, will be entered in a clinical record. When a member is transferred from domiciliary barracks to the hospital of the same facility, for any diagnostic or treatment episode comprehended in the foregoing, a supplementary Form 2593 will be prepared and distributed as provided, to show change of status, if the hospitalization exceeds 24 hours. If it is not necessary to hold the beneficiary overnight in the hospital, the "Actual number of days in hospital" will be entered on that form as "0", and the episode will not be reported under any item on Form 2601, Report of Hospitalization.

(2) To obviate the necessity of preparing and submitting a complete Form 2593 for every readmission comprehended by (C), the upper part of Form 2593 will be prepared upon the first readmission, showing that admission date as the date of the first treatment. The Form 2593 will then be held until the series of readmissions and treatments are ended, whereupon that form will be completed, with the date of final discharge corresponding to the date of the last treatment given. On the reverse of Form 2593 will be shown the inclusive dates of the treatment series. In a series of treatments, the hospital register number assigned for the first admission, will not be changed for the readmissions in the same series.

(3) To facilitate the computation of the correct number of in-patient days for each month, Form 2593 related to temporary hospitalization, will be placed in a separate section of the active Form 2593 file. When the service or series of services has been concluded, those Forms 2593 will be placed with others in the inactive section of Form 2593.

(F) Form 2817, Meal or Lodging Ticket, will be used to authorize maintenance during temporary hospitalization.] (August 15, 1944.)



## PHYSICAL EXAMINATIONS

[6465.] SAFEGUARDING OF EXAMINEES' FUNDS AND VALUABLES DURING PHYSICAL EXAMINATION.--Claimants or beneficiaries, upon reporting for out-patient physical examination, will be informed that the Veterans Administration will not be responsible for loss of cash or valuables during examination unless deposit thereof has been made before the examination is begun. If they wish to accept this protective service, they will be supplied an envelope, in which they will deposit, in the presence of an employee designated for this duty, their cash and valuables. The employee will record on the face of the envelope the amount of cash and the kind of valuables inclosed, will secure the signature of the examinee below this inventory, will seal the envelope and deposit it immediately in a secure place, preferably a safe, if available. The envelope will be returned to the examinee upon conclusion of his examination. He will be requested to count the contents and, if satisfied, to sign "Received in full", with date and his name upon the envelope. If he alleges loss of cash or valuables so deposited, the matter will be referred to the manager before the examinee leaves the station, for investigation and action. The signed envelopes will be utilized for other purposes or disposed of as waste paper. No claim for reimbursement of alleged loss of cash or valuables will be entertained after the examinee has left the station. (August 19, 1944.)

### [6466. PHYSICAL EXAMINATIONS FOR THE PURPOSES OF THE VETERANS ADMINISTRATION.--

(A) These are authorizable incidents of medical service:

1. Claims for disability pension or compensation.
2. Applications for payment of insurance benefits or waiver of premiums upon allegations of total or of permanent total disability.
3. Determinations whether insurants receiving the benefits of insurance payments or premium waiver have recovered ability to pursue a gainful occupation.
4. Applications for new insurance or reinstatement of United States Government Life or National Service Life Insurance.
5. Vocational rehabilitation.
6. Determinations of mental competency or incompetency looking to appointment or discharge of a guardian of a beneficiary.
7. The medical certificate on Form P-10, Application for Hospital Treatment or Domiciliary Care, will be executed, without charge, by a physician of any field station at which an applicant appears in person. No fee will be paid for its execution by any other physician.
8. Emergency officers retirement pay.
9. As a preliminary to medical treatment at field stations.
10. Examination of dependents of ex-members of the armed forces of the United States, e.g., a dependent child, upon allegation of helplessness or incapacity for self-support because of mental or physical defect; or a dependent widow or parent, entitled to pension or compensation, who is alleged to be mentally incompetent.
11. Prospective employees of the Veterans Administration (see R. & P. 6328).
12. Employees of the Veterans Administration, for protection of their health and that of beneficiaries, to prevent food poisoning, and to determine their mental and physical fitness to discharge their duties (see R. & P. 6329; 9226, 9670-71, and 9718).

(B) Authorization - Physical examinations made for the purposes of the Veterans Administration will be authorized for

1. Pension or compensation, by an adjudication officer (Form 2507) or by a central office official. See place of physical examinations.
2. Emergency officers retirement, by the chairman, board of veterans appeals, through the medical director.
3. Guardianship, by an adjudication officer or chief attorney.
4. Dependents, by a central office official, chief attorney, or adjudication officer.
5. Insurance purposes, by a chief medical officer under the provisions of R. & P. 3102, or by a central office official.
6. Examination in his home, of an applicant for reinstatement of insurance, by the director of insurance.
7. Plaintiffs in insurance suits, by a United States attorney.
8. Trainees, by a rehabilitation officer.
9. Prospective employees, by the designate of a chief medical officer or clinical director.
10. Employees, by the designate of a chief medical officer or clinical director.

(C) (1) Hospital observation and examination for disability rating purposes will be requested (Form 2507) by an adjudication officer, or by a central office official.

(2) When such examinee has a neuropsychiatric or presumed neuropsychiatric disorder, but which is not a frank psychosis, his admission for observation and examination will be to the nearest facility for general medical or surgical conditions, if there is a neuropsychiatrist on duty at such facility. If not, admission will be authorized to the nearest facility for neuropsychiatric patients which can provide the required privacy for the examinee during such hospitalization.] (August 19, 1944.)

[6467. PHYSICAL EXAMINATIONS FOR OTHER PURPOSES.--(A) Besides those for its own purposes, other physical examinations can be made by physicians of the Veterans Administration for

(1) Other Federal agencies, e.g., inductees into service with the Army or Navy; ex-members of the Navy or Marine Corps who are claimants for benefits under sections 4756 and 4757, revised statutes; applicants for annuity under Public No. 162, 75th Congress (45 U.S.C. 228a-228s), (Railroad Retirement Board); applicants for disability retirement from the Federal Civil Service, and annuitants so retired; beneficiaries and potential beneficiaries of the United States Employees Compensation Commission; prospective appointees to other Federal agencies; neuropsychiatric examinations of offenders against Federal Statutes.

(2) Pensioners of nations allied with the United States in World War I.

(B) Authorization -

(1) Such examinations (physical or laboratory) of inductees into the armed forces as may hereafter be necessitated, will be authorized by commanding officers or their responsible subordinates. That a charge must be made for such examinations will be made clear before they are undertaken. The War Department cannot pay for examinations of civilians who are being considered for employment, nor can the Navy Department pay for examinations of inactive reservists. A reservist in the service of the Veterans Administration cannot examine another reservist, upon request of the latter, during official hours of duty or with use of Veterans Administration equipment.



(2) Examinations for annuity under Public No. 162, 75th Congress, will be authorized by the Railroad Retirement Board, and the type of examination will conform to the terms of the request. If a general physical examination is requested, that only will be made (to include statement of distance vision by Snellen Chart and qualitative examination of urine for sugar or albumin). If it is thought that any specialistic examination, or X-ray or other laboratory procedure is indicated, the Board will be so informed by telegram, collect, and further action will be in accordance with the Board's reply.

(3) Examination of applicants for disability retirement or of persons in receipt of annuity after retirement, will be authorized by the Washington, D. C., office of the Civil Service Commission. For information regarding the procedure to be followed in examining an employee to determine whether he is physically qualified to perform his duties, see Regulations and Procedure, Personnel.

(4) Examination of beneficiaries and potential beneficiaries of the United States Employees Compensation Commission will be authorized by personnel officers of the Federal agencies in whose service the injured person is employed, or by the Commission.

(5) Prospective appointees to the service of other Federal agencies will be referred for physical examination by personnel officers of such agencies, or by regional directors of the United States Civil Service Commission. It must be made clear to such referring officials that any such physical examination made by the Veterans Administration will be subject to charge therefor at fees as provided. See R. & P. 6328 for instructions of the Civil Service Commission as to acceptance or rejection of applicants for "indefinite" war service appointments. The CSC Form 2413, medical certificate, that will be completed for each such examinee will be returned to the personnel officer of the referring Federal agency or the referring regional director of the Commission. (a) Prospective appointees to the Panama Canal service may be referred by the Washington, D. C. office, Panama Canal, or by regional directors of the Civil Service Commission, but the examination in either case will be charged to the Washington office, Panama Canal. (b) The director or assistant director of the Bureau of Prisons, Department of Justice, may request examinations for positions at Federal penal and correctional institutions. For this type of employment, medical certificate, Form 13a, requiring X-ray, blood count and other laboratory operations, is required. The letter from the director or assistant director will contain Form 13a and instructions pertaining to the examinations desired. (c) Superintendents of the fifteen divisions of the Railway Mail Service and certain chief clerks designated by them may request physical examinations of substitute railway postal clerks. The examinations are to be performed only at the headquarter cities, and will be at the expense of the Railway Mail Service, unless specifically authorized by a regional director of the Civil Service Commission. Accordingly, requests from the superintendents or the designated chief clerks may be honored, provided the request for examination stipulates that the cost of the examination will be borne by the Railway Mail Service. Requests from the Civil Service Commission will also be honored, with billing to the Commission. The headquarter cities of the Railway Mail Service are located at Boston, New York City, Washington, D. C., Atlanta, Cleveland, Cincinnati, Chicago, St. Louis, San Francisco, St. Paul, Fort Worth, New Orleans, Seattle, Omaha, and Pittsburgh.



(6) Neuropsychiatric examinations of Federal offenders will be requested by judges of United States district courts or by probation officers attached to such courts. The time and place for the examination will be specified in a court order.

(7) Pensioners of nations allied with the United States in World War I will be examined upon request of the medical director, except when initiative rests with a chief medical officer (or his designate, the chief of a general medical unit) under R. & P. 7503.

(C) All examinations under R. & P. 6467, are to be undertaken subject to the condition that they will not interfere with the conduct of examinations for monetary benefits provided by the Veterans Administration. Chief medical officers and clinical directors will arrange with referring officials of other Federal agencies for the appearance of their examinees in accordance with appointments made for and with those examinees. When examinations of prospective employees of other Federal agencies are made at isolated field stations of the Veterans Administration where meals or lodging are not obtainable in the local community, and it becomes necessary to hold over such examinee to complete a requested out-patient examination, he can be supplied lodging at \$1.00 and single meals at 50 cents each or \$1.00 for three meals until the examination is ended. Such items of maintenance will be added to the charge for the examination that is made upon the Federal agency concerned. The procedure in such hospital admissions will conform to that prescribed for temporary hospitalization in R. & P. 6462. To avoid holding-over of such examinees, their appointments should be for early in the morning.] (August 19, 1944.)

[6468. CHARGES FOR PHYSICAL EXAMINATIONS.--(A) For physical examinations made under R. & P. 6467, the charge will be 50 percent of those authorized by the Schedule of Fees for Medical Services, Veterans Administration. Thus, the charge for a general physical examination will be \$2.50 (to include statement of distance vision by Snellen Chart and qualitative examination of the urine for albumin and sugar). For each examination by a specialist, if authorized, the fee will be 50 percent of that authorized in the said schedule, provided that if such special examination cannot be made by a full-time or part-time physician at the field station of the Veterans Administration, and has to be obtained on a fee basis, the charge will be the cost thereof to the Veterans Administration. Beneficiaries and potential beneficiaries of the Employees Compensation Commission will not be referred to part-time or fee-basis designated physicians, as such reference would contravene the Commission's regulations (such physicians are not United States medical officers within the meaning of section 9, United States Employees Compensation Act). For each laboratory examination, in addition to a general physical examination, the charge will be 50 percent of the fee for such service as authorized in the aforesaid schedule, provided that if such laboratory examination is available only through a contractor, the charge will be the cost of the contractor's fee for the service. See added charges for meals and lodging, R. & P. 6467 (C).

(B) All such charges will be reported, on Form 1086, to the director of finance, for billing upon the Federal service concerned. See also transportation in out-patient activities, R. & P. 6460.

(C) Charges for physical examinations of Canadian or British pensioners, see R. & P. 7577.] (August 19, 1944.)



[6469. PRIORITY IN PHYSICAL EXAMINATIONS.--(A) Managers, to insure priority in considerations by disability rating boards, have been directed to classify pending claims for pension, filed by World War II applicants, in this sequence (subject to exceptions in favor of claimants or beneficiaries in a terminal condition, hardship of claimants or dependents, or other meritorious circumstances):

1. Combat injury cases, including "War neuroses," "exhaustion neurosis," or psychoneurosis originating in action or under bombing.

2. Cases, not included in 1, involving disability held in line of duty or aggravated by service, by the Army or Navy.

3. Cases, not included above, involving disability initially manifest so as to render the person unfit for duty, as shown by the certificate of disability for discharge, or by records of admission for treatment leading to discharge, after 90 days wartime service.

4. Cases not included above, involving discharge to a Veterans Administration facility, other recognized institution, or to the care of another person.

5. Cases, not included above, involving discharge for disability.

6. Cases, not included above, e.g., not involving discharge for disability.

(B) Chief medical officers or clinical directors and their designates will also accord priority in ordering physical examinations, in disposing of examinees who report at their stations, and in forwarding reports of physical examination to rating boards of jurisdiction, as herein prescribed; provided that exceptions may be made because of relative urgency in individual cases, as decided:

1. Original or reopened claims for disability pension, compensation, insurance, including waiver of premium, and to determine mental competency or incompetency. Examinations required for initial rating of combat disabilities or disabilities initially of record shortly after combat service will, upon request therefor from an adjudication officer or a claimant or his representative, be given priority over all other examinations except those required in terminal or emergency cases; provided that claim has been filed within one year after discharge from the armed forces.

2. In applications for vocational rehabilitation.

3. In claims for increased disability pension or compensation benefits.

4. In applications for new insurance or reinstatement of insurance.

5. In claims for disability pension rated initially on service records.

6. To determine whether an insurant who has been granted payments or waiver of premiums because of total or permanent total disability has recovered ability to pursue a gainful occupation.

7. Dependents.

8. Examinees of other Federal agencies.

9. Pensioners of nations allied with the United States in World War I.

(C) Applicants for hospital treatment or domiciliary care - since the primary consideration in these cases is the actual necessity for hospital treatment or domiciliary care, and the detailed findings essential to a report for disability rating purposes are not required, the medical certificate on Form P-10 will be filled out for these applicants as they present themselves at the station. Those who are emergently ill will be hospitalized after a prima facie determination of eligibility; the Form P-10 can be prepared later.] (August 19, 1944.)

## REQUESTS FOR AND PROCUREMENT OF PHYSICAL EXAMINATIONS

[6470. RESPECTIVE RESPONSIBILITIES FOR REQUESTING AND PROCURING PHYSICAL EXAMINATIONS.--(A) Adjudication officers and central office officials are responsible for determinations as to the necessity for physical examinations and reexaminations, and for appointing the date ("at once" or in the future) that an examination is wanted. Chief medical officers or clinical directors and their designates (a chief, reception-out-patient unit, or physician placed in charge of out-patient activities, or chief of unit as provided in R. & P. 6452) are responsible for determinations, in general, as to where and how the examination is to be made; except that requests of central office officials or of an adjudication officer for observation and examination in a hospital, or in a diagnostic center, will be carried out. The responsibility of medical officers, therefore, begins with the receipt of a request for examination, extends through its scheduling and procurement, assurance at the point of its production as to its adequacy from a medical viewpoint, and its delivery to the rating agency of jurisdiction. The rating agency will determine the sufficiency of the examination report for rating purposes, and, if any such report is returned by an adjudication officer as unsatisfactory, with statement as to its deficiencies, the chief medical officer, clinical director or their designates will -- if an explanation cannot lead to an adjustment -- procure an amended examination report embodying the amplification or definiteness that is desired.

(B) (1) Requests for physical examinations, originating at a regional office or facility with regional office activities, will be executed on Form 2507, Request for Physical Examination, in triplicate and signed by the adjudication officer. Of such requests -- whether examination is to be made at the same station, or be referred to another station or to a designated or private physician -- the original and one copy will be routed to the abstract unit, while the other copy will be inserted in the case file.

(2) Requests from central office may be on Form 2507 or by letter, radio-gram or telegram, as prompted by the relative urgency of the individual case. Under "remarks", Form 2507, or in such other medium of request, the type of the claim or application will be stated, if the priority in handling provided in R. & P. 6469 (B) is desired.

(3) Requests for physical examination, coming from central office or from another field station, will not be forwarded to the abstract unit at the receiving office, but will be sent to the chief medical officer or his designate in charge of out-patient activities.

(4) Requests for examination prepared in field stations having possession of the case files of the examinees, referred to other field stations for necessary action, will be transmitted by Form 2507a, medical and industrial history, summarized from data in the case files, by an employee of the out-patient service. If those files contain no such data, Form 2507a will not be prepared. Instead, the notation "Case file contains no medical or industrial history" will be entered under "remarks" on Form 2507.] (August 19, 1944.)

[6471. POSTING REQUESTS FOR EXAMINATION BY THE ABSTRACT UNIT; CALENDAR FILE.--When the original and copy of Form 2507, Request for Physical Examination, originating at the field station are received at the abstract unit (see R. & P. 6470 (B) (1)), this action will follow:



(A) If the request is for an "at once" examination, the original Form 2507 and copy will be attached to the case file of the claimant or beneficiary, and sent to the physician in charge of out-patient activities. He will, as determined, proceed with arrangements for calling the examinee to the station, or refer the original request to another station or to a designated physician.

(B) If the request is for examination at a future date, the original and the copy of Form 2507 will be placed in the calendar file after the date of the examination and its type (general, specialistic) have been posted under "physical examinations" on Form 6604, Abstract Card.

(C) (1) Every day, the abstract clerk will comb the calendar file, taking from it those Forms 2507 which show examinations set for six weeks later, and checking them against the abstract card, to ascertain if the examinations are still desired. If it appear that the examination is no longer desired, the Forms 2507 will be forwarded to the adjudication officer, who will indorse them "canceled", add the date, and return them to the abstract clerk, who will destroy them. If the abstract card shows no change in the request for examination, the Forms 2507 will be routed, as before, to the adjudication officer who will decide (a) whether the request is now to be canceled, or (b) a later date set for the examination, or (c) whether the examination is to be proceeded with. Should the decision be that the examination is no longer desired, the adjudication officer will indorse "canceled", with date, and send the Forms 2507 to the abstract clerk, for destruction, after correction of the entry upon the abstract card. If the adjudication officer decides to postpone the examination, he will specify the changed date upon the Forms 2507 and send them for placing in the calendar file, after correction of the set date on the abstract card. If he decides to proceed with the examination, he will return the Forms 2507 to the abstract clerk, with the indorsement "proceed". If the examination is to be made at the station, the original and copy of Form 2507 will, without delay, be thereupon routed to the physician in charge of out-patient activities, who will have them placed in the appropriate section of the examinations schedule.

(2) The adjudication officer will have made changes in the copy of Form 2507 placed in the case file, corresponding to those ordered to be made in the abstract cards and calendar file.] (August 19, 1944.)

[6472. EXAMINATIONS SCHEDULE FILE.--(A) Chief medical officers or their designates will be responsible for the setting of schedules of future physical examinations, and will maintain a file, to be known as the examinations schedule file, for this purpose. In devising these schedules, such officers will be guided by these considerations: (1) that there will be a balanced distribution of the daily examinations load for each week of the schedule (which will usually cover one month in advance), having regard to the number and kind (general examiners, specialists, laboratorians) of personnel who will be assigned to physical examinations for the schedule period, and the prescribed output for each medical examiner; (2) that the average daily output of completed examinations will be coordinated as much as possible with the production of the rating board or boards of the station, so as to expedite completion without congestion; and (3) that the schedules be fairly flexible, so that, if necessary, one or more extra examinations can be handled in the days work.

(B) The examinations schedule file will be established and maintained in correspondence with the essential groupings under section F II of Form 3400, Consolidated Monthly Report, so as to facilitate the compilation of statistical data for that



report. The exact situation in respect to the station's examination load can be readily determined from this file.

(C) The examinations schedule will be contributed to by Forms 2507, Request for Physical Examination, routed from the calendar file in the mail and records section (see R. & P. 6471), requests from central office or other stations, and such requests as had been issued by the chief medical officer or his designate, and had not been routed by either to the mail and records section for entries on Form 6604, Abstract Card, or incorporation in the calendar file. Before any Forms 2507, thus variously contributed, are placed in the examinations schedule file, the date of their receipt will be recorded (for counting at the end of the month) on the upper righthand corner; and since these forms, besides their primary purpose, are to serve the secondary purpose of control and statistical records, they will not be removed from this file until all required action has been taken. After completion of all action they will be extracted and destroyed in accordance with approved procedure for the disposal of inactive records.

(D) If a request for examination, from central office, is by Form 2507, letter, radiogram, or telegram, or if Form 2507 is sent by another field station requesting conduct of an examination, a simple tracer, bearing the name, C-number and name of referring station, can be inserted in the examinations schedule file.

(E) The examinations schedule file of Forms 2507 will be in three sections: (1) those requests originating at the station and when the physical examination is to be made at the station; (2) those referred by other stations; and (3) those referred to other stations. Sections 1 and 2 are to be subdivided into forms representing examinations for the day and examinations completed. The forms will pass between these subdivisions as action is taken. Section 3 will have two subdivisions: Forms representing examinations referred to other stations and pending report, and those completed by the other stations.] (August 19, 1944.)

## PLACE OF PHYSICAL EXAMINATION

[6474. AT NEAREST FIELD STATION.--(A) (1) Out-patient examinations of claimants or beneficiaries whose condition permits of the necessary travel will be made at field stations of the Veterans Administration; and at that station which is nearest the place of address of the examinee, regardless whether that place of examination is outside the territorial jurisdiction of the regional office or facility with regional office activities that requests the examination. The transportation and other expense incident to the completion of such examinations will be borne by the field stations at which they are made.]

(2) When the clinical director or his designate in charge of out-patient activities at a hospital facility, after receiving a request from a regional office or facility with regional office activities to conduct an out-patient examination, ascertains that the beneficiary's condition forbids travel, a full-time physician will be sent from the hospital to the home of the examinee, if the distance thereto does not exceed fifty miles. If the distance is greater than fifty miles, the request will be returned to the office which referred it, with suggestion that that office arrange home examination by a designated or private physician.] (August 19, 1944.)

[6475. AT OTHER THAN NEAREST FIELD STATION.--(A) Exception to the selection, as the place of examination, of that field station which is nearest the place of address of the claimant or beneficiary, may be made under these conditions:



(1) A chief medical officer or his designate, motivated by his experience in the procurement of examinations may, with approval of the manager, select, in an individual case, that place of examination at which he is assured he can obtain a satisfactory report.

(2) Examinations which are not made at the nearest field station to the examinee must be within the territory of the office desiring them, except that, when observation and examination in a hospital or diagnostic center is wanted, such hospitalization may be authorized in the nearest suitable hospital or diagnostic center, regardless of territorial lines.

(3) Employees of the Veterans Administration who are claimants or beneficiaries will be examined for purposes of disability ratings at that other suitable field station which is nearest the station to which they are assigned; except that member-employees in facilities for domiciliary care may be examined at those facilities.] (August 19, 1944.)

[6477. REFERENCE OF CASE FILES IN EXAMINATIONS.--(A) The case files of claimants or beneficiaries may be transferred temporarily, by central office or a field station, to the field station where a request for their examination has been referred, subject to these conditions:

(1) Such transfers will not be generally applicable to case files of persons whose only military or naval service was prior to April 6, 1917.

(2) Transfer of any case file will not be routinely requested. Since Form 2507, Request for Physical Examination, prepared at the field station having custody of the examinee's case file, will be transmitted by Form 2507a and the medical and industrial history of the examinee will be summarized on that form or the statement "Case file contains no medical or industrial history" will be entered on Form 2507 (see R. & P. 6470 (B) (4)); and since the Form 2507 will show the diseases and injuries, and the service connection or nonservice connection of the disabilities from them, together with information as to dates of enlistment, and discharge and character of discharge, there should be little need of consulting the claims file in the great majority of cases.

(3) If, after careful consideration of (1) and (2), it is the decision that transfer of a case file is actually necessary, the procedure will be as follows:

(a) In claims for which adjudication action has been decentralized, when a regional office or facility with regional office activities refers the examination to another station, the case file will be sent to such other station, upon request therefor in sufficient time before the examinee is to appear.

(b) In claims for which adjudication action has not been decentralized, transfer of case files will be asked by the station at which the examination is to be made, and in sufficient time before the examinee is expected to appear.

(c) The records specified in R. & P. 649 will not be subject to transfer with case files.

(B) Transferred case files will be returned without delay. It is not necessary to hold them pending the typing of a report of physical examination. They will be returned as soon as the examination is completed, or before then, if the file has been consulted in advance of the arrival of the examinees (as will be the practice in all possible instances).] (August 19, 1944.)

[6478. AT OTHER FEDERAL HOSPITALS.--(A) Such Federal hospitals (other than those under direct and exclusive jurisdiction of the Veterans Administration) as are

allocated a regional office or facility with regional office activities, may be used for examinations that cannot be made at the office (such as spinal puncture, electrocardiogram, basal metabolism rate, etc.), or for such examinations (e.g., a gastrointestinal X-ray series) that will require temporary hospitalization.

(B) Commanding officers of such other Federal hospitals will be asked to submit a physical examination report whenever the condition of a patient receiving treatment upon authorization of the Veterans Administration shows a notable change at the completion of the hospital treatment as provided in R. & P. 6482 (A) (1), (2) and (3). Such reports, which will be sent to the rating board of jurisdiction, as provided in R. & P. 6482 (D), will be rendered only if the patient is receiving or has applied for a monetary benefit.】 (August 19, 1944.)

【6479. BY DESIGNATED PHYSICIANS OR PRIVATE PHYSICIANS.—(A) (1) When the condition of a claimant or beneficiary forbids travel to a field station of the Veterans Administration or other Federal hospital, or economy in travel expense can be effected, a designated physician or private practitioner can be authorized to make such a general physical or a specialistic examination, without additional laboratory procedures, at fees in accordance with those allowable under the Schedule of Fees, Veterans Administration. This authority attaches to chief medical officers or their designates in regional offices or facilities with regional office activities; it is not vested in clinical directors or their designates in hospitals.

(2) During the present emergency, chief medical officers of regional offices and facilities with regional office activities, when the out-patient load is not on a current basis, and currency cannot be attained and sustained with the staff assigned to the work, are authorized to make wider use of designated physicians or dentists, for general or specialistic examinations, than heretofore was authorized; provided that such physicians or dentists are known to be competent and reputable, and that their services will be utilized only under the conditions as to currency of workload that are defined in the foregoing.

(3) In examinations of a claimant or beneficiary in his home, consideration will be given to the relative expense and advisability of detailing a full-time physician from a field station, instead of authorizing a designated or private physician to render the service.

(4) When an examination is to be made in the office of a designated physician, he will be sent Form 2513, Notice of Authorized Physical Examination, together with a Form 2639, Letter of Authority for Medical Service on Fee Basis, and a Form 2545, Report of Physical Examination, for return to the authorizing office. The claimant or beneficiary to be so examined will be sent either Form 2510 or 2514 (dependent upon whether transportation is necessary and furnishable at Government expense) directing him to report to the designated physician.】 (August 19, 1944.)

【6480.】 EXAMINATION OF CLAIMANTS OR BENEFICIARIES WHO ARE CONFINED TO PENAL INSTITUTIONS.—The chief medical officer concerned will arrange, through the manager, with the authorities of an institution, for the physical examination of a claimant or beneficiary who is confined in the institution. If a physician is on duty at the institution (who is not a Federal employee), an examination by him will be authorized at a fee in accordance with the Schedule of Fees, Veterans Administration, payment to be made to [him or to] the State concerned, [as the circumstances require.】 If such report be not satisfactory for rating purposes and adequate correction thereof cannot be secured for guiding instructions; or if a special type of examination



(physical or laboratory) is wanted and cannot be procured at the institution, arrangements will be made for conducting the examination by a full-time physician sent from the nearest station of the Veterans Administration. No claimant or beneficiary confined in a penal institution will be instructed to report to a field station or designated physician. (August 19, 1944.)

**[6481. EXAMINATION REPORTS FROM STATE OR PRIVATE HOSPITALS.--**Reports of physical examination of patients who are receiving treatment, authorized by the Veterans Administration, in State or private hospitals, will be requested by chief medical officers or their designates, when desired by adjudication officers.] (August 19, 1944.)

**[6482. EXAMINATION REPORTS RELATED TO TREATMENT IN A FACILITY UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--**(A) Besides the reports of physical examination which are submitted to disability rating boards following hospitalization for observation and examination, or after examinations in an out-patient unit, chief medical officers or clinical directors or their designates will submit reports of examination related to patients admitted for treatment, in these circumstances: (1) When, upon completion of the hospital treatment, the patient presents a notable change in the disease or injury for which he is being paid disability pension or compensation, or for which he has received payments of Government insurance or been allowed waiver of insurance premiums. (2) When increased disability is evident from a condition, service-connected, which is currently evaluated at less than 10 percent. (3) When the patient indicates in writing that he is claiming or will claim additional or greater disability benefits. (4) When an incompetent veteran on whose behalf an institutional award has been approved is released on a trial visit a report will be forwarded for rating purposes within a reasonable time not to exceed ninety (90) days.

(B) Such reports will not be required when a patient hospitalized for treatment is not in receipt of or has not applied for a monetary benefit from the Veterans Administration.

(C) Members in domiciliary care will be entitled under (A) (3).

(D) Such reports will be submitted to the office of adjudicative jurisdiction, upon Form 2545, Report of Physical Examination. At the left top corner, first page, under the number of that form, will be entered "Notable change upon completion of treatment as provided in R. & P. 6482 (A) (1), (2) and (3)." If no notable change of condition has occurred, no report of physical examination will be submitted.] (August 19, 1944.)

**[6483. EXAMINATION REPORTS RELATED TO OUT-PATIENT TREATMENT.--**(A) Physical examinations made, in an out-patient unit, to determine need for hospital treatment or domiciliary care, or to guide to change or continuance of treatment, or to note progress, are not required to be of the formal, detailed character essential in examinations for the purpose of rating disability, and are not intended for such purpose.

(B) If, however, upon completion of out-patient treatment, a notable change of condition is observed in the beneficiary, a Form 2545, Report of Physical Examination, will be prepared for submittal to the office having adjudicative jurisdiction, in the manner provided in R. & P. 6482 (D).

(C) When a beneficiary reports for out-patient treatment, the physician in charge of that activity will have the calendar file consulted to note if a physical examination of the patient, for disability rating purposes, is set for a reasonably near future date. If such be the case, the adjudication officer will be informed and asked if, as a convenience to the beneficiary and to save the expense to the



Government of his later travel to the station, the beneficiary cannot receive his physical examination for rating purposes before leaving the station. The adjudication officer, if consenting, will indorse the pending Forms 2507 and the case file copy, "proceed", with date. Appropriate action will be taken to clear the abstract card.

(D) When a chief medical officer or his designate ascertains from the reports (Forms 2690 or 2690a) sent in by a designated physician that a beneficiary receiving authorized treatment by him is showing notable change in condition, he will request the designated physician for a report of the patient's condition, to be sent by the chief medical officer to the rating board.】 (August 19, 1944.)

【6484.】 EXAMINATIONS NOT TO BE MADE BY A PHYSICIAN WHO HAS PRESENTED A STATEMENT ON BEHALF OF THE CLAIMANT.--A reexamination under R. & P. R-1186 will not be authorized to be made by a physician who has presented a statement or affidavit on behalf of the veteran in connection with his claim. In referring an examination to another field station, that station will be informed of the name and address of the physician, if any, who has submitted such statement or affidavit, so as to insure compliance with this provision. It is to be understood that this prohibition has no application in cases where a designated physician has submitted a statement in connection with the rendering of authorized out-patient treatment. (August 19, 1944.)

【6485. PHOTOGRAPHS TO SHOW DEFORMITIES, SCARS, ERUPTIONS, ETC.--When an examinee has deformities, scars, skin eruptions, etc., which it is thought would influence the rating for degree of disability, chief medical officers or clinical directors or their designates are authorized (if the pictures cannot be taken with equipment at the station) to incur expense for necessary photographs, not retouched, to accompany the report of physical examination, provided that not to exceed \$2.00 will be expended for any one such photograph.】 (August 19, 1944.)

#### FOLLOW-UP ON REQUESTS FOR EXAMINATIONS

【6486. ROUTING OF UNDELIVERED FORMS.--(A) When any of the forms (2510 or 2514) sent a claimant or beneficiary requesting him to present himself at a field station or to a designated or private physician for physical examination, are returned undelivered, they will be routed to the abstract desk, for check of correctness of the address.】

(B) If a new address is not found entered on the abstract card, other records, such as the person's case file (if in possession of the station) or Forms 404 or 2593 (showing possible admissions to a facility) should be consulted. If the case file is in another office, the inquiry will be directed thereto. If a new [and more recent] address be found, that is within the territory of the examining station, the form will be readdressed accordingly [and be reissued.】 If an ascertained new address be temporary, and in the territory of another station, the [readdressed] request for examination will be referred thereto.

(C) 【If no new address be found, the undelivered form will be indorsed "Abeyance, pending address," by the abstract clerk, and will be routed, with the original and copy of the Form 2507, Request for Physical Examination, which had been placed in the calendar file, to the adjudication officer, who will send the Form 2510 or 2514, as the case may be, and the request, Form 2507, for insertion in a separate file, designated "Abeyance Form 2507 File."】



(D) If a new address is received within three months of such abeyance filing, the chief medical officer or his designate may proceed with arrangements for the examination, after concurrence of the adjudication officer. The forms so held in abeyance will be taken from the file, for appropriate action (reissue of Form 2510 or 2514 with corrected address, replacing Form 2507 in the calendar file, changing notations on the abstract card, and assigning a new date in the examinations schedule file).

(E) If, upon expiration of three months after abeyance filing of an undelivered form, no new address has been provided, the chief medical officer or his designate will close out the examination. The forms will be taken from the abeyance file and, after indorsement "Time expired; examination attempt closed" by the chief medical officer or designate, will be sent to the adjudication officer. The latter, after signing the forms, will route them to the case file.]

(F) When any of the said forms is returned with request for postponement of the examination, without any reason for such request, the claimant or beneficiary will at once be informed that unless he furnishes an adequate reason for deferring the examination, it must be proceeded with as scheduled. If, in reply, he furnishes a reason and the period of requested postponement is for a period not exceeding one month, the chief medical officer is authorized, if he considers the reason adequate, to set a future date for the examination. In all cases where a reason for postponement is not considered satisfactory, or when the desired period of postponement exceeds one month, the chief medical officer will consult the adjudication officer, who will decide whether postponement shall be granted or the claimant or beneficiary directed to report upon the date that has been set. The chief medical officer will take action accordingly. If, within ten days after the mailing of the letter to a claimant or beneficiary advising him that he must furnish an adequate reason for his request for postponement, no reply is received, the chief medical officer will certify "Failure to Cooperate" on the Form 2507 and route it to the adjudication officer for his information and any action as to suspension of awards, etc., he considers necessary. The adjudication officer will certify "Abeyance", with his initials on the form, and send it for placing in the "Abeyance Form 2507 File."

[(G)] If an examination in which a claimant or beneficiary has failed to cooperate is one that had been requested by central office, the request for examination will be returned to the head of the service concerned in central office, with a brief explanation of the facts related to the failure to cooperate.

[(H)] If within three months after a Form 2507 has been placed in the "Abeyance Form 2507 File," claimant or beneficiary supplies sufficient reason, either in writing or in personal appearance at the station, for failure to cooperate, the chief medical officer will so inform the adjudication officer. If the latter desires the examination to be proceeded with, he will indorse "proceed" on the form, and return it to the chief medical officer, who will arrange the examination.

[(I) If, upon expiration of three months after his Form 2507 had been placed in abeyance because of failure to cooperate, a claimant or beneficiary has furnished no explanation of his failure, attempt to arrange his examination will be closed out, with observance of the procedure in (E).] (August 19, 1944.)



## APPROVAL OF REPORTS OF PHYSICAL EXAMINATION

[6488. (A) Reports of physical examination relative to patients hospitalized for treatment (see R. & P. 6482) or hospitalized for observation and examination; as well as reports of physical examinations made in the out-patient unit of hospitals, upon requests referred from regional offices and facilities with regional office activities, will be scrutinized by clinical directors or their designates to determine medical adequacy, that is, whether the diagnoses are fully supported by the physical findings and symptomatology; all necessary laboratory procedure, X-ray and clinical, have been utilized in the study of the case; the data are clear and sufficiently full, with no conflicts; and the nomenclature accords with that currently in use for the Veterans Administration. When satisfied on those points, the clinical director or his designates will indorse the report (at its end) "approved," followed by the initials of the officer and the date.

(B) Reports of examinations made in regional offices or out-patient units of facilities with regional office activities, whether upon requests originating at the station or referred by another station, will be scrutinized and indorsed, if satisfactory, in the manner provided in (A), by chief medical officers or their designates.

(C) Any report which is unsatisfactory to a chief medical officer or a clinical director or their designates, will not be forwarded to a rating board of jurisdiction, but will be returned to the physician who prepared it, with a sufficient statement of its deficiencies, for full correction or amplification, and return to the approving officer.

(D) The rating agencies under the direction of the adjudication officer will determine the sufficiency of examination reports for rating purposes. Reports which are found to be deficient in any essential particular will be returned to the chief medical officer, with sufficient statement of the nature of the inadequacy, and the chief medical officer will procure a corrected report that will be satisfactory to the rating authorities.

(E) That thorough familiarity with the Manual for Medical Examiners which is required of examining physicians is expected to inform them of the needs of rating boards in respect to reports of examination.] (August 19, 1944.)

## CONDUCT OF OUT-PATIENT EXAMINATIONS

[6490. (A) ORGANIZATION.--Chief medical officers or clinical directors or their designates will assign a sufficient number of physicians - general examiners and specialists, full-time or part-time - to clear the daily schedule of out-patient examinations, having regard to those who will be absent on sick, official or annual leave. The provision of clerical aid and of an adequate number of typists to meet the necessity of prompt transcription and forwarding of reports of examination is essential; as well as of messengers to accompany examinees and to carry papers. The examining floor should be capacious enough to allow of free movements of personnel and examinees. Quiet will be enforced. Neuropsychiatric examinations will require privacy, and proper accommodations should be provided for eye and ear examiners. See R. & P. 6450 as to delegations of authorities by chief medical officers or clinical directors to chiefs, reception-out-patient units or other designates placed in charge of out-patient activities, and see R. & P. 4224 as to furnishing signatures of designates so empowered.



(B) Methods - (1) A general physical examination will be made even if the sole or main complaint is referable to a disease or injury suggestive of a specialistic examination, and any specialistic examination which is needed will be added where the history and complaints are mainly indicative of a disorder of a general medical or surgical type. When it is impracticable to obtain a general physical examination and a specialistic examination by different physicians, the specialist will record the general examination in addition to his specialistic one. When the history and complaints point to predominance of a general medical or surgical condition, the examination will be begun, whenever possible, by a general examiner who, upon conclusion of his examination, will refer the examinee for any needed specialistic or laboratory examination.

(2) To economize the time of examining physicians, all claimants or beneficiaries reporting at the out-patient unit will be directed to a clerk assigned, under general supervision, to record answers to questions 1 to 3 and 6 to 9, inclusive, on Form 2545, Report of Physical Examination (the data under questions 4 and 5 will be elicited and recorded by the examining physician). This clerk will be supplied the Forms 2507, Request for Physical Examination, and case files that are available which are related to the examinees scheduled to appear for the day. If the examination is an initial one, the medical and industrial history will be fully developed, including the names and addresses of physicians who may have treated the examinee, and dates of such treatment; names and addresses of any hospitals in which the examinee had received treatment, and dates of such treatment; and the names of employees and places of former employment, with dates. If the person had received previous physical examinations by the Veterans Administration, the medical and industrial history will be brought up from the date of the most recent of such former examinations. The clerk will enter the factual data elicited upon a work sheet of plain scratch paper, identifying the answers by the question numbers 1, 2, 3 and 6, 7, 8, 9 to correspond with Form 2545; and will deliver or have a messenger take the examinee, the work sheet, Form 2507 and case file, to the physician who has been appointed to distribute, direct and coordinate the examinations for the day.

(3) That directing physician will require full-time examiners to make the ordinary examinations of body systems (that is, eye, ear, nose and throat, or orthopedic or genito-urinary examinations), calling upon the attending specialists of the staff only when specialistic services are actually necessary. Test of distant vision by the Snellen Chart will be a part of a general examination. The directing physician, from the Forms 2507 and case file and work sheet sent him by the clerk aforesaid, will decide to what physician the examinee will first be referred: this should preferably be a general examiner, if one be unoccupied; but if specialistic examination be indicated, the examinee can first be sent to the specialist, if he be not engaged. The directing physician will deliver or have a messenger deliver the work sheet with the clerk's entries, the Form 2507 showing the examination wanted, the case file if available, and the examinee, to the physician selected to begin the examination. This latter physician will have before him a copy of Form 2545, Report of Physical Examination, and will record the physical signs and symptoms developed by him, upon the work sheet, in the sequence of numbers on the Form 2545, carefully identifying the data by the question numbers of Form 2545. At stations where dictating equipment is used, or where stenographers are available for dictation by a medical examiner, the same care will be taken to follow the sequence of questions on Form 2545, and



to identify the answers by the question numbers. Upon completion of his part of the examination, this first examiner, if a specialist, will deliver or have a messenger deliver the work sheet, Form 2507, case file and examinee to a general examiner; or, if the first examination was a general one, the physician who made it, if a specialistic examination be indicated, will deliver or have a messenger deliver the examinee and exhibits just named, to the specialist. If no specialistic examination is indicated, the general examiner will deliver the examinee and all exhibits named, to the directing physician, who will arrange for such laboratory examinations as are required in the case.

(4) When all examinations, general, specialistic and laboratory, as needed, are completed, the work sheet or sheets, Form 2507 and case file, will be sent to the directing physician, whose first step will be to have the answers to questions 8 and 9 typed on Form 2545, for signature by the examinee before he leaves the station. The directing physician will then assure himself that the work sheets are complete, that all necessary examinations have been made, and that the data are satisfactory. If he notes any deficiencies, lack of fulness or clarity, or conflicts in findings, the examinee will not be dismissed until the data have been fully corrected. If the data are satisfactory, the directing physician will route the work sheets, with the Form 2545 bearing the examinee's signature below questions 8 and 9, for typing of complete reports on Form 2545 from the work sheet data.

(5) The purpose of the work sheet is to conserve Forms 2545. Extra sheets, of plain scratch paper, will be added, as needed, to the original sheet used by the clerk aforesaid; but each such extra sheet, brought into use by examining physicians, will be identified by the name and C-number of the examinee, bear a number in sequence of pages, and be firmly attached to the original introduced into use by the clerk. The last numbered extra sheet will bear a notation of the total of extra sheets.

(6) Only one Form 2545 will be typed, for incorporation in the case file, provided that if the examinee has a service-connected disorder for which he has received or is receiving out-patient treatment, a carbon of the physical examination report will be made for his medical file (out-patient). The examinee will be questioned regarding this.

(7) Typists, after copying on Form 2545 the work sheet data, will hold both until the examining physician (or physicians) has compared them and has affixed his (or their) signature. Sufficient space will be left after typing each section, to accommodate a signature needed at the point. If only one examiner had made the examination, his signature will be placed at the end of the form. No examiner will affix another's signature. In court trials for Government insurance benefits it is the physician who made the examination in question who is called to testify to the genuineness of the signature and the findings recorded. In examinations by a board, the report will be signed by each member of the board. If two or more examinations, recorded on the same Form 2507, Request for Physical Examination, were made upon different days (as when a specialistic examination had preceded or followed a general physical examination), the dates of each examination will be entered on the report, Form 2545.

(8) The date of the typed Form 2545 will be that of the completion of the examination, not the date of typing.

(9) Chief medical officers or clinical directors or their designates will approve and indorse reports of physical examination as provided in R. & P. 6488, (6490 Continued)



before forwarding them to the office having adjudicative jurisdiction; and will secure any necessary correction or amplification of defective reports, as provided in that paragraph.

(10) When a physical examination requested by central office is made at the field station, Form 2507 or other type of request that was used will be returned with the Report of Physical Examination, Form 2545, and the case file if that had not been previously returned. The central office, upon receipt of the request form and the report, will indorse "Examination report received," with date and initials of the receiving employee upon the request form and send it to the station which had forwarded it. If the station which receives a central office request for examination finds it necessary to refer the making of the examination to another field station, the request form will be so referred, and central office will be notified of the reference of the examination. Such notice will clear the responsibility of the station which had originally received the request. The station to which the examination had been referred will, after it is completed, return the report thereof, together with the request to central office, where, upon receipt of the request, it will be indorsed as above provided, and be sent to the station at which the examination had been made. Should such station to which the examination had been referred think it necessary to consult the case file, central office will be asked to forward it, subject to return with the request form and report, or before then if possible (see R. & P. 6477).

(11) Work sheets (after the data on them have been transcribed to Reports of Physical Examination, Form 2545) and the Forms 2507, Requests for Physical Examination, will be routed by the examining station to inactive storage, held one year, and then recommended for destruction under R. & P. 637.

(12) All possible economy will be exercised in the use of X-ray film in examinations. Form 2614q, Clinical Record - Report of Electrocardiogram, will also be used in out-patient examinations. If the examinee has a medical treatment file in the out-patient unit, the electrocardiogram stapled to the Form 2614q, will be placed in that file. If there be no medical treatment file, the Form 2614q and its mounted tracing will be placed in inactive storage with the work sheets and Form 2507 requests and disposed of as provided in (11).

(13) Interpretations of radiograms and electrocardiograms will be recorded on the Reports of Physical Examination, Form 2545.

(14) Nomenclature of Diseases and Conditions, Veterans Administration, will be used in preparing examination reports.

(15) Study of the Manual for Medical Examiners will be enjoined upon all examining physicians.】 (August 19, 1944.)

6492. PERSONS POTENTIALLY ENTITLED TO OUT-PATIENT TREATMENT.--Chief medical officers and clinical directors or their designates, such as a chief, reception-out-patient unit, or the physician placed in charge of out-patient service, may authorize out-patient treatment, determined as needed, for [persons defined and under the conditions stated, in R. & P. R-6060 (A) and (B).] (October 9, 1945.)

6493. APPLICATION FOR OUT-PATIENT TREATMENT.--[Form 2827 will be supplied for execution by persons defined in R. & P. R-6060 (A)(1) to (6), inclusive, who request out-patient treatment in person or by mail. That form will not be required for out-patient treatment of persons defined in R. & P. R-6060 (A)(7) and (8). Approved applications will be placed in medical files created for out-patient treatment. Rejected forms not requiring adjudicative action as prescribed in R. & P. 6494 (B) and (C) or if no medical file has been created will be kept in a manila folder for one year, and then recommended for disposition as inactive records.] (October 9, 1945.)

6494. DETERMINATION OF ELIGIBILITY FOR OUT-PATIENT TREATMENT OF EX-MEMBERS OF THE ARMED FORCES.--(A) At all facilities and regional offices; an eligibility clerk or other employee designated in lieu, will be assigned to determinations of eligibility for out-patient treatment. All applicants appearing in person, all mail or telegraphic requests for such treatment, and all references for the conduct of out-patient treatment that are made by other field stations, will be routed to this employee.

(B)(1) When a person who has not previously applied for a monetary or treatment benefit appears in person at an out-patient unit, exhibits a certificate of discharge for disability (with notation, "Section II, AR 615-360" [or "section I, AR 615-361"],) or similar papers showing a disability discharge from World War II; and his condition be emergent or semi-emergent, he will, in the absence of evidence indicating non-eligibility, be held as showing prima facie eligibility for treatment, and may be furnished it, including necessary medicines and supplies. [The service will be discontinued if formal eligibility, based upon official service records, be not subsequently established.] This authority does not extend to treatment outside of the station.

(2) Prima facie eligibility is determinable by the clerk aforesaid. The applicant will execute Form 2827, Application for Out-patient Treatment, and, if prima facie eligibility be shown, the clerk will indorse the application "Prima Facie Eligibility Established", with his signature and date, and deliver or send the applicant and the indorsed Form 2827 to the physician in charge of out-patient activities. The latter will place the form in a medical file created for the beneficiary, and proceed with his treatment. If no prima facie eligibility be shown, the applicant will be informed that out-patient treatment cannot be provided, and the reason for disallowance will briefly be explained to him; the application will then be placed with other disallowed applications to be recommended for disposition as inactive records, as provided in R. & P. 6493.

(3) When formal eligibility is approached following a finding of prima facie eligibility, the eligibility clerk will procure the medical file of the applicant, with its contained Form 2827 [ ] certified as provided in (2); will arrange the assignment of a C-number and will forward the [file to the adjudication officer for processing], with request for determination of service connection for the condition or conditions for which out-patient treatment has been requested. Upon completion of consideration, the adjudication officer will return the [ ] file, with a formal rating employing the applicable code, to the eligibility clerk. The latter



will return the [ ] file, in which will be fastened the rating sheet received from the adjudication officer to the physician in charge of out-patient activities. If the rating sheet shows service connection for the condition or conditions requiring treatment, the said physician will have the [ ] file placed in the active section of such files. [If no service connection be shown the file will be put in the abeyance file subject to release should the person later file claim for a monetary or other benefit.]

(C) When in circumstances not emergent or semi-emergent, it is ascertained from the applicant that he has not filed a claim for disability pension or compensation, the eligibility clerk will place the executed application, Form 2827, [in a file, and succeeding action will accord with that prescribed in (B)(3). To comply with the provisions of this paragraph and (B)(3) above, the eligibility clerk or other employee designated in lieu, at field stations not having adjudication activities, will forward the file or medical file to the regional office or facility with regional office activities having jurisdiction.]

(D) If the applicant has filed a claim for disability pension or compensation and his case file be in possession of the office at which he requests out-patient treatment, the clerk aforesaid will execute Form 505 and forward it to the adjudication officer. Upon return of that form, executed by the adjudication officer, the action of the clerk will be as follows: If service connection be shown for the condition requiring treatment, the application, Form 2827, and the Form 505 will be delivered to the physician in charge of out-patient activities, who will place both forms in a medical file created for the applicant, and will authorize his treatment. If service connection be not shown for the condition requiring treatment, the rejected application, with the Form 505 affixed to it, will be filed and disposed of as provided in R. & P. 6493.

(E) If the applicant for out-patient treatment has filed a claim for disability compensation or pension but his case file is not in possession of the station at which he applied [Form 505, Request for Data, etc., in duplicate, will be forwarded by the clerk to the adjudication officer of the field station or central office] in possession of the case file. Upon return of the executed form, the clerk will follow the action prescribed in (D).

(F) An applicant for out-patient treatment who had received hospital treatment for a service-connected disorder under R. & P. R-6047 (A) or (B) will, ipso facto, be entitled to out-patient treatment for the same disorder, provided that service connection for it has not been severed, or that he is not in an uncleared status of an irregular discharge from hospitalization or domiciliation. Notice of severance of service connection will be furnished by adjudication officers concerned (for filing in treatment files), and irregular discharges from hospitalization or domiciliary care will be reflected in Forms 2593 filed in case files of the beneficiaries involved.

(G) [(1)] Since out-patient treatment of applicants receiving vocational rehabilitation [under Public No. 16, 78th Congress], has no relation to service connection of the disorder for which such treatment is required [but may be furnished for any disorder to avoid interruption of such rehabilitation], the foregoing provisions pertaining to eligibility do not attach, and the eligibility clerk or other employee aforesaid will refer such applicants directly to the physician in charge of out-patient treatment. [(See also R. & P. 6555 (D).)]



[(2) Treatment of any disorder which will cause irregularity or absence of the trainee from the prescribed course of training will be reported to the rehabilitation officer. Treatment given for a venereal infection will be reported to the rehabilitation officer with information whether training can, medically considered, feasibly be continued.

(3) The physician responsible for out-patient treatment of trainees, whether rendered at field stations or on a fee basis will maintain close liaison with the rehabilitation officer, who will consult such physician should interruption of training due to physical or mental incapacity of the trainee be contemplated. This procedure will also be applicable to trainees who are being furnished hospital treatment.

(4) Responsible station personnel will bear in mind that out-patient treatment on a fee basis or hospital treatment in a civilian or State contract or non-contract hospital (except for hospital treatment in the territories and possessions of the United States and for women war veterans, as provided in R. & P. R-6050), authorized for treatment of a nonservice-connected disability to avoid interruption of training must be terminated as of the date that training is interrupted.]

(H) No adjudicative action is required for the furnishing of adjunct treatment; the chief medical officer or clinical director or their designates will authorize such treatment in accordance with the principles outlined (see adjunct treatment). (October 9, 1945.)

6495. OUT-PATIENT TREATMENT OF PENSIONERS OF NATIONS ALLIED WITH THE UNITED STATES IN WAR.--See R. & P. 7525, 7538, 7577, etc., as to authority and fees, and R. & P. 4357 as to vouchers for the services rendered. Such treatment will be recorded on Form 2565. (August 19, 1944.)

6496. OUT-PATIENT TREATMENT OF EMPLOYEES OF THE VETERANS ADMINISTRATION AND THEIR FAMILIES.--Treatment of an employee (other than as an ex-member of the armed forces entitled to out-patient treatment, or as a beneficiary of the Employees Compensation Commission) can be provided if private services are not feasibly available. The like principle will apply to employees' families. Fees as provided will be charged. (August 19, 1944.)

6497. OUT-PATIENT TREATMENT OF BENEFICIARIES OF OTHER FEDERAL AGENCIES.--(A) Officers or enlisted personnel of the Army, Navy, Marine Corps or Coast Guard, in active service, will be furnished out-patient treatment, including necessary medicines or supplies, when authorized by their commanding officers or responsible medical officers of their service.

(1) Authorizations from such Army officers under Public No. 177 and Public No. 852, 76th Congress, will be typed or written, and will specify the name of the referred soldier and the treatment desired. That authorization will be attached to the Veterans Administration Form 1086 that is forwarded to the director of finance, reporting the service, for billing upon the War Department. An officer or enlisted man of the Army, absent from his command on leave or without official leave, or on furlough, or in transfer to another post, can, upon his request, be supplied out-patient treatment in an emergency without the authorization aforesaid, but it will be obtained as promptly as possible after the emergency treatment is rendered.

(2) Authorizations for treatment of personnel of the Navy or Marine Corps will be similar to those in (1) hereof. An officer or enlisted man who, absent from his ship or station on liberty or permitted leave, applies to a field station for treatment, will be supplied it if his condition be medically emergent to the extent



that naval medical facilities are not reasonably available, and the applicant has not been more than thirty days absent from his ship or station. Request for authorization to cover such emergency treatment will, without delay, be made upon the patient's commanding officer. Report on Form 1086 to the director of finance will be made as provided in (1).

(3) There is no authority for treatment of families of officers or enlisted men of the Army or Navy, by the Veterans Administration, except that emergency treatment can be rendered when private physicians are not feasibly available, subject to charges at fees provided.

(4) Beneficiaries of the United States Employees Compensation Commission, or its potential beneficiaries placed under treatment following determination that their injury was received in performance of duty, will receive all necessary out-patient treatment, to be reported on Form 1086 to the director of finance. The Commission will accept charges for such treatment, in cases where claim has been disallowed, up to the date of such disallowance. The beneficiary will be billed for such continuance of treatment as is necessary after such disallowance.

(5) Interned aliens may be provided out-patient treatment upon request of officials in charge of such camps with report on Form 1086 to the director of finance, for billing upon the Department of Justice. If it is necessary that a physician of the field station of the Veterans Administration visit such camp to render treatment, the entire cost of his travel and per diem allowance will be included in the charges, and the treatment of each alien will be billed in the total account. (August 19, 1944.)

6498. OUT-PATIENT TREATMENT OF THE GENERAL PUBLIC IN EMERGENCIES.--As a humanitarian measure, and when the services of private physicians are not feasibly available, out-patient treatment may be furnished members of the general public brought to the out-patient unit of a Veterans Administration field station, following traffic or other accidents in the vicinity. Following emergency treatment, such persons will be referred to private physicians. The service will be charged at rates provided. (August 19, 1944.)

6499. FEES FOR OUT-PATIENT TREATMENT.--The fee for each out-patient treatment of a pensioner of a nation allied with the United States in war; of beneficiaries of other Federal agencies; of employees of the Veterans Administration (not treated as entitled ex-members of the armed forces or beneficiaries or potential beneficiaries of the Employees Compensation Commission); of families of those employees; and members of the general public given emergency treatment as a humanitarian measure, will be 50 percent of the fee authorized in the Schedule of Fees for Medical Services, Veterans Administration, that is \$1.00. This will include dressings, and ordinary but not expensive medicines (e.g., insulin, liver extract, serums, etc.,) which will be charged at unit cost to the Veterans Administration. Reports of treatment of members of the general public and of employees and employees' families (except potential beneficiaries of the United States Employees Compensation Commission) will be made on



Form 1216; collection will be made at the station concerned for treatment of employees and their families. Reports of treatment rendered beneficiaries of other Federal agencies will be made to the director of finance on Form 1086. Reports of treatment of pensioners of allied nations will be made on Form 1082.] (August 19, 1944.)

6500. [MEDICAL FILES FOR OUT-PATIENT TREATMENT.--(A) A medical file will be created at every regional office and facility for every applicant who has been determined eligible for out-patient treatment.

(B) Medical files will be alphabetically arranged, and will consist of active and inactive sections. The active section will contain files of patients who are beginning or continuing treatment. The inactive will consist of files relative to applicants for whom treatment has been terminated, and those who have not been under treatment for six months.

(C) In regional offices, medical files will be kept in the mail and records unit. In facilities without regional office activities, they will be in charge of the clinical clerk, but kept in the out-patient unit. In facilities having regional office activities, when greater convenience and expedition will be served, the inactive section of medical files may be kept in the mail and records unit, and the active section be maintained in the out-patient unit, in charge of the clinical clerk. The privacy of these files will always be preserved, and they must always be inaccessible to patients.

(D) (1) CONTENTS - A medical file will consist of the approved application Form 2827 revised; any notice of severance of service connection (see R. & P. 6494 (F)); any copy of Form 2557, showing admission for hospital observation or treatment; records of station treatment previously administered, including physical therapy; dietary regimen; any Prosthetic Appliances Service Card, Form 2529; prescriptions of medicines, syringes, dressings, sputum cups or other supplies furnished; a short record of operations performed, with dates; any copy of physical examination report (see R. & P. 6490 (B)(5)); notes of progress or findings during the course of treatment; and any copies of Form 2639, fee services, Form 2690, Designated Physician's Request for Authority for Treatment, and Form 2690a, Report of Treatments Rendered. Records of dental relief or prosthesis will not be placed in the medical files. Notations of the final dental rating on non-compensable conditions will be made on Form 2688, Dental Master Card, which will be retained as a permanent record, by the chief dental officer, and will be referred to instead of a copy of the rating sheet in the medical files. The chief dental officer will maintain these Forms 2688 indefinitely in the inactive section of his files.

(2) Medical files for out-patient treatment are comparable, in professional and possible medico-legal significance, to clinical records of in-patients. These files will be kept in a neat, orderly arrangement, with the eligibility exhibits affixed to the inside of the front flap. If a notice of severance of service connection be received, it will be fastened prominently over the eligibility exhibits. Entries will be legible, sufficiently full, and always dated. The identity of the disease or injury under treatment will be recorded. Each notation will be signed by the physician who made it. The records will be current. Plain sheets will be used. Prescriptions will not be identified by number, but by ingredients and dosage. Routine refilling of prescriptions will not be practiced. Notations of clinical progress should show some consistent relation to the therapy program. When an out-patient's condition is not improving or is retrograding, hospitalization will be considered.



(3) Episodes of hospitalization will be reflected in the medical file of a beneficiary. Copies of Form 2557, routed for incorporation in these files will show admission to the facility at which the out-patient is receiving treatment, or to another facility, including a Federal or private hospital. But the applicant for out-patient treatment will be interrogated, also, as to his hospital history. Had he been previously under observation or treatment in the facility that is to provide his out-patient treatment, the clinical records of his former hospitalization will be procured from the clinical clerk, and will be summarized for his out-patient medical file. Had he been hospitalized at some other facility, a summary of that hospital episode will be requested, for incorporation in his medical file. Such clinical records as are supplied by another Federal or private hospital to the regional office or facility having regional office activities that had authorized treatment of a beneficiary in such hospital will be routed (after serving the purpose of determining notable change in condition, as provided in R. & P. 6478) to medical files.

(4) Similarly, upon admission of a beneficiary for hospital treatment, the possibility that he may have a medical file in the out-patient unit of the facility will be kept in mind, and the chief, reception-out-patient ward will procure such file if it exists, and transpose any desired data from it to the clinical records of the in-patient. Also, such patient will be interrogated (in developing his previous medical history) regarding any former out-patient treatment at any other field station of the Veterans Administration, and a summary of such out-patient service may be requested.

(5) Medical files of the beneficiaries concerned will be consulted in authorizing treatment by a designated physician or private practitioner, especially in regard to previous hospital episodes.] (August 19, 1944.)

6501. [MEDICAL FILES FOR TRAINEES.--See R. & P. 6492 (A) (2) and 6494 (G). Such files as had been created for out-patients will be continued in use for them if they are granted vocational rehabilitation by the Veterans Administration. All that will be necessary - when the out-patient treatment is rendered in the course of vocational reeducation - is to record it in the file, under the date of out-patient contact, as "Trainee Treatment." If, when a trainee applies for out-patient treatment, it is found that no medical file had previously been set up for him, because he had not been handled as an out-patient before he entered training, an out-patient treatment file will be created for him, and the appropriate notation "Trainee Treatment" will be the first entry in the records to be placed in such file. No special, separate out-patient treatment files will, accordingly, be prepared for trainees. For the reporting of out-patient services rendered such beneficiaries, see item 5, "Vocational Rehabilitation," Form 2565, Monthly Report of Out-patient Services.] (August 19, 1944.)

6502. [TRANSFER OF MEDICAL FILES.--(A) When the case file of a beneficiary is transferred to another field station because of permanent change of address, his medical file, if one exists, will also be transferred. And, in death of a beneficiary in a facility, his treatment file, if one exists, will be forwarded with his case file to the office having adjudicative jurisdiction of death benefits.

(B) When one field station requests another, closer to the place of residence of a beneficiary, to take over his out-patient treatment, there will be sent to such other station the medical file, with eligibility data, and any other contents that may have been developed. The medical file will then remain in possession of the station to which it has been referred, until circumstances in (A) arise.] (August 19, 1944.)



6503. [PLACE OF OUT-PATIENT TREATMENT.--(A) As with the making of physical examinations, out-patient treatments, - to economize travel expense and to convenience beneficiaries - will be rendered at that field station nearest their place of residence, except when a chief medical officer or his designate has a cogent reason for conducting the treatment at the station having territorial jurisdiction, rather than referring it.

(B) Out-patients referred to another station must be capable of travel to it, and this will be ascertained before the reference. If it is not, and the treatment has been requested at a facility without regional office activities, a full-time physician may be sent to the home of the patient, provided that it is not more than fifty miles distant. If the distance is greater, the request for treatment will be returned to the referring station, with suggestion that that station arrange treatment by a designated or private physician.

(C) All expense incident to travel of an out-patient will be borne by the station rendering the treatment, except that when an Army, Navy or Public Health Service hospital, allocated to a regional office or facility having regional office activities is used, the transportation will be attended to by such office.

(D) Beneficiaries receiving vocational training will ordinarily be provided necessary out-patient treatment through the field station supervising his training, but the treatment may be referred to another field station nearest his place of training or residence; or authorized (if his condition forbids travel) for rendition by a designated physician. Admission to a contract hospital can be authorized, if a Federal hospital (and preferably one under the direct and exclusive jurisdiction of the Veterans Administration) is not feasibly available. The handling of prescriptions, supply of medicines and dressings, and furnishing of orthopedic appliances, etc., will be as for out-patients in general, with the understanding that service connection of an intercurrent disease or injury or the usual principles of adjunct treatment are not considerations in the treatment of trainees. Treatment is to be given to prevent interruption of training. For treatment of venereal infections and type of dental relief to be furnished trainees, see R. & P. 6492 (A) (2). See also R. & P. 6494 (G) as to determination of eligibility, and R. & P. 6501 for trainees' medical files.] (August 19, 1944.)

[6504.] HOME TREATMENT NOT AUTHORIZABLE WHEN HOSPITALIZATION IS REFUSED.--When it is determined by a chief medical officer that an applicant for treatment at home, or a beneficiary who has been receiving such authorized treatment, is in need of hospitalization but able to travel; and hospitalization is offered and refused, the applicant will be informed that treatment at home cannot be begun and the beneficiary advised that treatment at home cannot be continued. However, such applicant or beneficiary may be furnished out-patient treatment at a field station, if reporting there with transportation at his expense. (August 19, 1944.)

6505. [OUT-PATIENT TREATMENT FOR APPLICANTS CONFINED IN OR PAROLED FROM A PENAL INSTITUTION.--(A) Out-patient treatment will not be provided by the Veterans Administration for applicants serving a sentence in a penal institution. Such service is to be supplied by the prison authorities.

(B) An applicant for out-patient treatment who has been discharged from a penal institution may, if eligible therefor, be supplied it.]

(C) The Veterans Administration will not request nor take part in any arrangements looking to parole of a prisoner from a penal institution. If a beneficiary, paroled through action of the proper authorities, other than for the purposes of



receiving care or treatment in a Veterans Administration facility, applies on his own initiative for [out-patient treatment, and is determined to be eligible therefor, such treatment] may be supplied subject to these conditions: That the Veterans Administration will accept no obligation for the custody of or the administration of punishment to such beneficiary (if known to be in a paroled status) during his treatment [or for his return to the civil authorities during or upon completion of his treatment] (except as provided in (D) hereof). The superintendent of the penal institution from which the beneficiary was paroled will be put on notice accordingly.

(D) When parole of a prisoner is proposed by civil authorities of jurisdiction for the purpose of securing for him medical treatment by the Veterans Administration, it will be required by the manager of the field station to whom such request is made that the superintendent of the penal institution certify in writing why adequate facilities for the needed medical treatment are not available at the institution. If the explanation be satisfactory, the Veterans Administration may supply such [ ] out-patient treatment as the paroled beneficiary requires and for which he is eligible. The conditions stipulated in (C) will apply during the treatment of a patient paroled under this, subparagraph (D), except that when completion of treatment is approaching and the patient is to be discharged by the Veterans Administration, the civil authorities that had granted the parole will be notified (registered mail, return receipt) of the day and hour of such discharge. (August 19, 1944.)

6506. OUT-PATIENT TREATMENT FOR BENEFICIARIES DISCHARGED FROM A FACILITY BECAUSE OF INFRACTION OF DISCIPLINE.--Beneficiaries who have received an uncleared irregular discharge from a facility [ ] will be considered for out-patient treatment of a service-connected disease or injury or adjunct treatment thereof, under the following conditions:

(A) If the condition of such applicant for out-patient treatment be medically determined as emergent, hospital treatment is decided necessary, and the required travel can safely be made, he will be offered hospitalization, in the nearest suitable facility under direct and exclusive jurisdiction of the Veterans Administration. If the travel to such facility be determined excessive with regard to his condition, a nearer suitable other Government hospital, allocated to the contacted regional office, may be chosen. A contract civilian hospital will be used only when a Government hospital is not feasibly available, or its use would necessitate extended travel, and when it is definitely known that the applicant's condition needing hospitalization is service connected or entitles to adjunct treatment [ ]. Such emergency hospitalization may be authorized whether the prescribed period of exclusion from hospitalization has or has not expired. Transportation and other expenses incident to travel for such hospitalization will be borne by the applicant, except when he or his representative alleges inability to pay the costs of such travel, and an affidavit in accordance is executed as provided [ ]. If the applicant or his representative refuses the proffered hospitalization, he will be informed that treatment in his home cannot be authorized.

(B) If the circumstances are the same as in (A), except that travel to a hospital would not be safe in medical judgment, treatment at home, for the period of the emergency only, will be authorized. When the emergency has passed, hospitalization, if then needed, will be offered, but further treatment at home will not be authorized.

(C) If the beneficiary's condition is not emergent, but hospitalization is indicated, it will be offered upon lapsation of the prescribed period of hospital exclusion, if then indicated. No medical service at home will be authorized; but out-patient treatment will be provided if such beneficiary reports at a field station, with transportation at his expense.



(D) Follow-up will be made on the emergency treatment authorized under (B), so that prompt action as therein provided may be taken after the emergency has passed.

(E) Beneficiaries with uncleared penalty for infraction of facility discipline who report (at their own expense for transportation) to a field station for treatment under (C), may be supplied necessary medical supplies as a part of such treatment, or such supplies may be mailed to their homes.

(F) Lapsation of the prescribed period of exclusion from hospitalization will entitle to out-patient treatment, with furnishing of transportation, as provided. (August 19, 1944.)

## OUT-PATIENT SERVICES AND SUPPLIES

6509. ARTIFICIAL PNEUMOTHORAX REFILLS.--Patients who previously had received artificial pneumothorax treatment by authorization of the Veterans Administration under the provisions of laws in effect prior to March 20, 1933, but who had been determined by adjudicative action as not entitled to such treatment under Acts subsequent to that date, may nevertheless continue to receive such refills as are found necessary, on an out-patient status, at field stations, until such time as artificial pneumothorax treatment may be discontinued in medical judgment; Provided, That such persons will be required to defray the cost of transportation to and from the station at which such treatment is rendered. (August 19, 1944.)

6510. DRUG ADDICTION.--(A) Drug addicts will be authorized only hospital care and treatment, subject to the conditions applying to hospital admission; Provided, That out-patient treatment of drug habitues entitled to such treatment because of a service-connected condition or as adjunct thereto, may be rendered in the following circumstances:

(1) Narcotics may be prescribed in actually required amounts, as medically determined for entitled beneficiaries who are in a terminal condition, or who are presenting a medical emergency.

(2) Such treatment will be continued only for the period of actual emergency or until hospital treatment can be arranged.

(B) Treatment authorized under (A) will always be under close supervision of the chief medical officer concerned, and will be conducted in compliance with the applicable regulations of the Treasury Department. (August 19, 1944.)

6511. SUPPLIES FOR OUT-PATIENTS.--(A) Clinical thermometers will not be supplied beneficiaries.

(B) ATOMIZERS AND NEBULIZERS.--For a prescribed spray, an atomizer or nebulizer of standard type may be supplied. Replacements or repairs may be made, but requests therefor will not be approved routinely; consideration will always be given to necessity for continued use of the article, and if the condition for which it was originally prescribed no longer exists or requires no further treatment, replacement or repairs will not be authorized. Beneficiaries will be cautioned to maintain proper care of articles so supplied, and will be informed that replacements or repairs can be made only when necessitated through ordinary wear and tear, or loss or breakage not due to negligence of the patient. Atomizers or nebulizers to be used for administration of sprays prescribed by designated physicians will be supplied by the regional office or facility having regional office activities; designated physicians will be so advised, and instructed to furnish the name and address of such patient, to whom will then be forwarded the atomizer or nebulizer. (August 19, 1944.)

[(C)(1) HYPODERMIC SYRINGES AND NEEDLES.--These will not be supplied beneficiaries for administration of narcotics. They may be supplied, with a sufficient amount of an epinephrine preparation, as medically determined necessary, to asthmatics who



are determined by the chief medical officer or his designate as sufficiently trained for self-administration. They may also be supplied with a sufficient amount of insulin or protamine zinc insulin subject to the determinations aforementioned to diabetics, provided their dietetic and insulin regime have been established.

(2) Except in emergency, hypodermic syringes and needles will be supplied by regional offices or facilities with regional office activities. Replacement, based upon medical judgment, may be made when necessitated through ordinary wear or tear, or loss or breakage not due to negligence of the beneficiary.

(3) When required by State laws or city ordinances, a certificate showing for what condition the syringe was furnished, signed and dated by the chief medical officer or his designate, will be furnished the beneficiary.

(D) Atomizers, nebulizers, hypodermic syringes and needles, replacements and repairs as provided in the foregoing may be furnished only for treatment of a service-connected disability or for a nonservice-connected disability which in medical judgment may be treated as adjunct thereto.] (September 12, 1945.)

6512. SICKROOM ACCESSORIES.--(A) Air cushions, air pillows or air mattresses; back rests; bedpans; urinals; enema cans and fountain syringes; ice bags, hot water bags, electric heating pads, and rubber sheeting may be supplied patients suffering from service-connected diseases or injuries, for use at home, subject to these conditions:

(1) None of these articles will be routinely supplied, but will be authorized only when determined medically as actually needed [for treatment of a service-connected disability or for a nonservice-connected disability which in medical judgment may be treated as adjunct thereto]. (September 12, 1945.)

(2) They will not be automatically replaced, but reissued only upon a determination of present needs. (August 19, 1944.)

(B) [Wheel chairs, regular or folding, subject to the controlling conditions specified in (A) hereof, will be supplied beneficiaries only upon approval of the chief medical officer, or his designate, of a regional office or facility having regional office activities. Request for such approval will contain a full account of the circumstances. Wheel chairs sufficient to meet estimated needs will be procured by requisition in the usual manner. Wheel chairs furnished as provided herein will not be furnished upon memorandum receipt subject to return as station property, but will be dropped at time of issue on credit voucher, Form 136. (For furnishing wheel chairs upon discharge from hospital treatment or domiciliary care for a nonservice-connected condition, see R. & P. 6893).] (September 12, 1945.)

6513. EMPLOYMENT OF PRACTICAL NURSES.--Registered graduate nurses only will be employed in authorized nursing service for an entitled beneficiary under treatment in his home; except that in exceptional circumstances precluding employment of such nurse, a so-called "Practical Nurse" (that is, one not a registered graduate of an accredited school of nursing) may be engaged at fees not in excess of those charged for like service in the community concerned. Such fee will be agreed upon before authorization is issued. The initial authorization will be for not to exceed [thirty] days service of such nurse; continuance beyond that period will require approval of the medical director, to whom a full statement of the circumstances will be submitted in making a request for such continuance. (September 12, 1945.)

6514. FOOD RATIONING OF OUT-PATIENTS.--Chief medical officers, clinical directors or their designates are authorized to supply, upon request, certificates to food-rationing boards, intended to secure, for out-patients, additional foods necessary for their condition. Such certificates will be furnished only upon well-considered medical grounds. (August 19, 1944.)



## SERVICES OF DESIGNATED PHYSICIANS

6518. [CONDITIONS GOVERNING EMPLOYMENT OF DESIGNATED PHYSICIANS.--(A) When travel of claimants or beneficiaries to a field station is inadvisable because of their physical condition, designated physicians can be authorized to make physical examination of such persons when required for disability rating purposes (see R. & P. 6479), or to render them treatment for which they are eligible; Provided, That such arrangement is more economical than travel of a full-time physician from a field station, or that it is not decided advisable to use a full-time physician in an individual instance, regardless of comparative expense involved.

(B) When a designated physician is not available, the services of a suitable private physician can be utilized, at fees not in excess of the Schedule of Fees, Veterans Administration.

(C) Chief medical officers will arrange for appointment of such sufficient number of designated physicians as will meet territorial needs. Form 2554 revised, will be used in submitting nominations of such physicians for appointment on a fee basis. Nominations of designated physicians for part-time employment will be accompanied by an executed Field Classification Sheet, Personnel Form 3810, and the number of hours monthly that such appointees are to devote to the duties will be specified. These appointments are in grade P&S 4, minimum.

(D) Penalty envelopes may be supplied part-time designated physicians, to be used only for official communications.

For utilization of designated physicians in the making of physical examinations for disability rating purposes, see also R. & P. 6479.] (August 31, 1944.)

6519. [AUTHORIZATION, FEE BASIS, OR SERVICES OF DESIGNATED PHYSICIANS.--(A) Services to be rendered by a designated physician employed on a fee-basis status will be authorized by Form 2639, Letter of Authority for Medical Services on Fee Basis. The service, whether physical examination or medical treatment, may be rendered at the office of the physician or in the home of the claimant or beneficiary, dependent upon the latter's condition. A designated physician may also be authorized to attend a patient who is receiving treatment in a civilian hospital as a beneficiary of the Veterans Administration.

(B) For proper medical administration and to facilitate preparation and auditing of vouchers, the terms of authorization on Form 2639 must be specified, particularly in these respects:

(1) Under 1, nature of service required, will be stated the character of the service (examination or treatment) desired; type of examination (general or specialistic, specifying the type of the latter), or type of treatment (medical, surgical, etc.); the disease or injury or diseases or injuries to be treated; and the number of visits. These will be specified as home or office visits. The period of validity of the authorization will be stated.

For treatment other than in hospital, when its continuance for a prospective period can be anticipated, the initial authorization will be for the number of days from the date of the authorization to the end of the same month. Thereafter, as needed, extensions may be authorized (in new authorizations) for the requisite additional number of days, but not to exceed one month. However, so that authorizations may be in the hands of designated physicians by the first of the month upon which they are to continue treatment, the Form 2639 will be dated



and issued before the end of the expiring month of authority. Thus, Form 2690, Designated Physician's Request for Authority for Treatment, is to be submitted the 23d of the month, so that Form 2639 can be prepared and issued by the chief medical officer or his designate in time for the designated physician to begin his continued treatments upon the first of the succeeding month.

(2) Under 2, the fee or fees will be stipulated.

(3) For notations under 3, class of beneficiary, the instructions on the back of Form 2639 will guide.

(C) Authority for treatment by a designated physician carries authority for furnishing such medicines and supplies as he may prescribe. The chief medical officer or his designate will, however, control excessive issue of supplies and arrange for filling of prescriptions at the station pharmacy, as elsewhere provided. Supplies for certain out-patients (or such patients themselves) can better and more economically be handled through the field station than through a designated physician. This arrangement would be applicable, for examples, for patients who are actively tuberculous, or who have chronic bronchitis, varicose veins or ulcers, discharging sinuses, etc., where it is evident that supplies will be needed, and monthly issues can be estimated and made. It would be in order, too, for asthmatic patients whose self-administration of insulin has been authorized; for diabetic patients whose insulin dosage has been stabilized; patients requiring sippy powders and mineral oil; patients suffering from chronic arthritis for whom analgesics and liniments are used, etc. From time to time such patients should be called into the field station, to observe their progress, change treatment or diet, etc.

(D) Form 2639 will be prepared in quadruplicate, but only the original and one copy need be signed by the authorizing officer. The three copies will be on plain tissue sheets, to economize Form 2639. The original will be sent to the designated physician. The signed copy (or a certified one) will be attached to the voucher for the service. Of the remaining copies, one will be supplied the finance officer, and the other will be placed in the treatment file of the beneficiary.

(E) When, in an emergency, authorization to render treatment has been given to a designated physician by telephone or telegram, formal issuance of a covering fully executed Form 2639 will promptly follow. On the face of that form, in the space below the seal, will be typed, "Confirming informal authority given by (telephone) (telegram)," followed by date of informal authority.

(F) Form 2504, Decision of Questions of Fact and Law, will be executed and attached to vouchers indorsed by the chief medical officer or his designate, covering service procured on a fee basis. See R. & P. 4311 for preparation of Form 2504. See also preparation and certification of vouchers for medical services in R. & P., Finance and Medical.] (August 31, 1944.)

6520. [AUTHORIZATION OF SERVICES BY PART-TIME DESIGNATED PHYSICIANS.--The use of Form 2639 being restricted to services on a fee basis, authorizations to part-time designated physicians to make a physical examination or render treatment, at the home of a claimant or beneficiary, or in the physician's office, or in a civilian hospital, will be conveyed by a letter. If such authority covers treatment for the ensuing month, it will be issued before the end of the month so that the designated physician may begin the treatment on the first of the succeeding month. A separate letter is not necessary for each beneficiary whose treatment is to be rendered by the same designated physician. The chief medical officer or the physician in charge of out-patient



activities will list, in one letter of authority, the names of all beneficiaries who are to be treated by the part-time physician during the next month; the disease or injury of each such beneficiary for which the treatment is to be rendered will be specified, as will the number of treatments to be given each. These letters of authority will be prepared in duplicate. The original will be mailed to the part-time designated physician; the copy will be placed in the station folder pertaining to the physician.] (August 31, 1944.)

6521. FORMS 2690, DESIGNATED PHYSICIAN'S REQUEST FOR AUTHORITY FOR TREATMENT AND 2690a, REPORT OF TREATMENTS RENDERED.--(A) These two forms (a sufficient supply of which will be supplied them to meet their current needs) will be used by designated physicians, both fee basis and part-time.

(B) Form 2690, as indicated by its title, is to be used in requesting any type of authority, whether initial (in either an emergent or non-emergent case) or for continuance of treatment. This form, in requesting initial authority to begin treatment, will be submitted as occasion requires, provided that, in emergent cases, when treatment has been rendered, it will be forwarded within 24 hours of the rendering of such emergency treatment, so that such service, if the patient be eligible therefor, may be covered by authorization. Form 2690, when used to request continuance of a series of treatments that had previously been authorized, will be mailed on the 23d of each month, so that the chief medical officer or his designate will be in receipt of it by the first [day] of the succeeding month, and can prepare and issue Form 2639 [to a fee-basis, or a letter of authority to a part-time designated physician,] authorizing continuance of treatment in cases which he determines it is needed.

(C) Form 2690a, as its title indicates, is a report of treatments rendered. It is to be mailed at the end of each month, by both fee-basis and part-time physicians who have rendered services [during] the reported month. A fee-basis physician will [enclose with] the Form or Forms 2690a his bill for the services rendered the beneficiary or beneficiaries concerned.

(D) While Forms 2690 and 2690a carry directions for their preparation [and submittal,] chief medical officers, when instructing designated physicians as to their duties (see R. & P. [6522]) will emphasize those directions, especially as to] the administrative necessity of forwarding Form 2690 within 24 hours after rendering treatment in an emergency.

[(E) Forms 2690 (individual) and 2690a will be placed in the treatment files of the beneficiaries concerned, after they have served their other purposes. But Forms 2690 referable to a group of patients will be placed in the station file pertaining to the physician.] (August 31, 1944.)

6522. [INSTRUCTIONS TO DESIGNATED PHYSICIANS.--(A) It is vitally important designated physicians be fully instructed by chief medical officers or officers in charge of out-patient activities regarding limitations of their authority, use of forms, preparation and submittal of reports, and all other procedure related to their services. This necessity is presented particularly as regards new appointees.

(B) Designated physicians will be informed regarding the terms of R. & P. R-6060, defining persons entitled to out-patient treatment and conditions of eligibility therefor, entitlement to adjunct treatment, under R. & P. R-6060 (B), will be determined by chief medical officers or their designates, and not by designated physicians. How an uncleared irregular discharge from hospital affects eligibility for out-patient treatment will also be explained to designated physicians.



(C) When an alleged ex-member of the armed forces applies for the first time, upon his own initiative, to a designated physician, for treatment, the designated physician will be instructed to ask him to show his certificate of discharge (i.e., whether for disability, honorable, dishonorable, or not dishonorable). The nature of the disease or injury leading to discharge for disability from World War II will not have been entered on the applicant's discharge certificate. If the applicant cannot exhibit a certificate of discharge, he will be asked to show any letters received from the Veterans Administration, furnishing at least prima facie evidence of eligibility. Designated physicians will be instructed that such exhibits do not entitle the applicant to authorize treatment other than as hereby provided:

(1) If such applicant's condition is not emergent, the designated physician will inform him that treatment cannot be rendered until authorization therefor has been received and will promptly forward an executed Form 2690, embodying the information he developed as to dates of enlistment and discharge, character of discharge, tentative diagnosis and such findings as were noted, to the regional office or facility with regional office activities concerned, asking authorization to treat the applicant. The chief medical officer or his designate will determine eligibility as provided (R. & P. 6494) and will inform the designated physician whether the applicant is or is not eligible. If he is eligible, the designated physician can be supplied executed Form 2639, or letter authorizing treatment, dependent upon whether he is on fee or part-time basis.

(2) If such applicant's condition, though not actually emergent, indicates prompt treatment, and prima facie eligibility is determinable from the papers exhibited by the applicant, the designated physician may render the treatment presently indicated, provided he requests authority, on Form 2690, which will be put in the mails as soon as possible and not later than 24 hours after he rendered the treatment. The chief medical officer or his designate, upon receipt of the Form 2690 will issue an authorization through a completed Form 2639 if the designated physician be on a fee basis, or letter of authority if he be on a part-time salary basis. Upon the formal authorization as issued will be typed: "Formal authorization for treatment rendered by you. (date)". (See also R. & P. 6522 (C) (5).)

(3) If such applicant's condition is emergent, treatment may be rendered by the designated physician, subject to submittal of Form 2690 as provided in (2). Action as provided in (2) will be taken by the chief medical officer or his designate.

(4) A designated physician may be authorized to telephone or telegraph the chief medical officer concerned if necessary in an emergency, and the cost of such messages (and the replies of the chief medical officer) will be borne by the regional office or facility with regional office activities concerned. Designated physicians will be cautioned not to cause such expense in any other than actual emergencies. If the chief medical officer or his designate has given telephoned or telegraphed authority to furnish treatment, he will confirm that action by preparing Form 2639 (for fee-basis service) or letter of authority (for service by a part-time designated physician) and will place a copy, affixed to the telegram or transcription of the designated physician's telephoned message, in the medical file of the beneficiary.

(5) Designated physicians will be advised that emergency treatment must necessarily be rendered upon their responsibility, subject to the foregoing conditions; and that, if reported within 24 hours as provided, and eligibility exists, the emergency treatment will be covered by due authority; but, if not so reported, the authorization cannot be retroactively dated and, if the applicant be ineligible, authorization cannot be issued at all.



(6) If a designated physician had previously rendered authorized treatment for a beneficiary and, subsequent to the completion of such treatment, the beneficiary applies again for treatment; and the condition of the applicant is emergent or, if not emergent, yet indicates prompt treatment, the designated physician may render the presently needed treatment, provided he submits Form 2690 within 24 hours, reporting such treatment and requesting authority to continue it.

(D) Designated physicians will be instructed to submit, in a consolidated certified bill comprehending all authorized services rendered during a period of one month, at the end of that month. Two or more separate bills covering authorized services rendered at different times during a month, will not be submitted.

(E) Designated physicians will be advised that they have no authority to hospitalize applicants for treatment. In reporting, on Form 2690, that they have been contacted by an applicant, designated physicians will state, in the space provided therefor on that form, whether hospitalization is indicated. If the applicant's condition is emergent, they will advise the chief medical officer or his designate of any necessity for prompt hospitalization, by telephone or telegraph, as provided in (C) (4) hereof. All action looking to hospitalization will be taken by the chief medical officer or his designate. See R. & P. 6078, emergency hospital admission. (August 31, 1944.)

6523. PRESCRIPTIONS OF DESIGNATED PHYSICIANS.--(A) A sufficient supply of Form 2577, Prescription Blank, will be furnished designated physicians, for use in prescribing medicines for beneficiaries under authorized treatment. The designated physician will be instructed to forward prescriptions to the regional office or facility. But, if the prescription is for a medical emergency, the physician will complete and sign it in duplicate, sending both copies to a druggist, preferably one under contract. The druggist will retain the original, have the beneficiary affix his receipt signature on the copy, and forward the copy, with his invoice, to the station, for [payment purposes.]

(B) If [a station] pharmacist has filled a prescription sent in by a designated physician, as required under (A), the medicament or supplies will be mailed to the patient or to the designated physician (if so requested). The same procedure will be followed in refills [of prescriptions,] which will be made only upon request of the designated physician. Prescriptions sent in by designated physicians to stations need not be in duplicate. See mailing of narcotics. [ ] (August 31, 1944.)

6524. [FEE-BASIS SERVICE BY A PRIVATE PHYSICIAN, NURSE, CLINIC OR LABORATORY.-- (A) See R. & P. 4312 as to statement to be supplied when noncontract services are utilized. The procurement of the services of a private physician as a consultant (at field stations which have an attending staff) will require the prior approval of the medical director, who will be informed as to the circumstances leading to the request. In emergency, that request can be made by radiogram or telegram. A nurse - preferably registered but, when a registered nurse is not available, then a practical nurse - may be authorized in the home treatment of an entitled patient; Provided, That if a claim for compensation or pension has been filed by such patient the fact that a special nurse has been authorized will be reported to the adjudication officer for action regarding any claim for or award of an additional allowance for a nurse or attendant. If economy can be realized by procuring a service from a clinic rather than referring the beneficiary to another field station of the Veterans Administration, such circumstances will be reported to the medical director, whose prior approval will be required. The same procedure will apply to private laboratory utilization.



(B) The services in (A) comprehend such as, for sufficient reason, could not be or were not obtained under contract. Procurement of these noncontract services will be covered by Form 2639, Designated Physician's Authority for Medical Services on a Fee Basis, and Form 2504, Decision of Questions of Fact and Law, will be executed.] (August 31, 1944.)

## CIVILIAN HOSPITALS

6525. [AUTHORIZATION OF ADMISSIONS TO CIVILIAN HOSPITALS.--(A) See R. & P. R-6050, Utilization of Facilities Other Than Those Under Direct and Exclusive Jurisdiction of the Veterans Administration.

(B) Form 2557, Admission Card, will be used by a chief medical officer or his designate, to authorize admission for treatment to a civilian hospital, whether under or not under contract.

(C) Form 2639, Designated Physician's Authority for Medical Services on a Fee Basis, will be used, together with Form 2557, in admissions to a hospital not under contract, with the fees specified on Form 2639.

(D) Form 2639 will not be used in admissions to a hospital under contract, except when it is necessary to authorize special services which are not furnishable under the flat per diem rate of the contract, such as a private room, a special nurse, blood transfusion, laboratory tests, special medicines or supplies, etc.

(E) Form 2504, Decision of Questions of Fact and Law, will be executed for such hospital admissions.] (August 31, 1944.)

6526. [ ] SURVEYS OF HOSPITALS.--In each regional office or facility with regional office activities in whose territory is located a facility or facilities (other than those under direct and exclusive jurisdiction of the Veterans Administration) where authorized treatment is being provided beneficiaries of the Veterans Administration, a hospital survey board will be organized. Such board wherever possible will have three members. The first member and chairman will be a full-time physician of the station concerned; this member will preferably be a physician trained in neuropsychiatry if the hospital to be visited is primarily one for care of neuropsychiatric patients. The second member will be the clinical director of the hospital visited or an alternate designated by the head of the hospital. The third member will be another full-time physician of the station, whenever possible; when, as in smaller stations, such number is not available, the board will consist of the two members provided in the foregoing. The board will be appointed by the manager of the station, upon recommendation of the chief medical officer. The second member will join the board when it convenes at the hospital to be visited.

(B) DUTIES.--A hospital survey board will be instructed to make a thorough survey of Veterans Administration beneficiaries in Federal hospitals (other than those under direct and exclusive jurisdiction of the Veterans Administration) and State, municipal and private hospitals of the regional territory to determine whether such beneficiaries are: (1) receiving the proper care and treatment in accordance with agreements or contract terms; (2) are being treated for the disease or injury specified in the authority, and are not being held for an intercurrent disorder, not authorized for adjunct treatment by the chief medical officer; (3) are being overhospitalized and can safely be discharged or referred for domiciliary care; (4) are in need of continued treatment and can safely be transferred to a suitable

facility under direct and exclusive jurisdiction of the Veterans Administration where beds are available; (5) have passed the stage of a medical emergency - where admission was authorized only for the period of an emergency - and can be discharged or transferred to a facility under direct and exclusive jurisdiction of the Veterans Administration.

(C) INTERVALS OF SURVEYS.--These will be made semi-annually, on or about January 15 and July 15, but only after prior authority is obtained from the medical director, to whom recommendation as to the conditions obtaining and need for the survey will be submitted. The names of the physician or physicians who it is proposed shall serve on the board will be submitted at the same time. This submittal to the medical director will be made at least one month before a survey is due.

(D) REPORT OF BOARD.--Upon conclusion of its survey of each such hospital, the chairman of the board will make recommendations as to disposition of each beneficiary concerned. A copy of this recommendation will be supplied the head of the hospital, for such comment as he desires to make. A second copy will be retained at the station. The original will be forwarded to the medical director. Respectful consideration will be given comment from the hospital head, but the manager may direct full carrying out of the board's recommendations, regardless of such comment, if the manager approves the findings and report of the board.

(E) FOLLOW-UP REPORT.--Immediately upon completion of all action based upon approved recommendations of the board, the manager will submit a follow-up report thereof to the medical director. (August 31, 1944.)

6527. [JURISDICTION OVER HOSPITALS.--(A) The central office will formulate policies governing the utilization of all Veterans Administration facilities (as defined in Veterans Regulation No. 10 (b), paragraph XIX); will allocate facilities under the direct and exclusive jurisdiction of the Veterans Administration, and other Federal hospitals, to field stations (Bulletin No. 24 series); and will prescribe the standards of care and treatment, supplies and equipment, personnel and procedure in facilities under direct and exclusive jurisdiction of the Veterans Administration, and standards of minimum requirements for contract hospitals.

(B) The administrative supervision of beneficiaries of the Veterans Administration receiving authorized treatment in other Federal hospitals (Army, Navy, Public Health Service, and in State, municipal or civilian hospitals, will be a responsibility of managers of regional offices and facilities with regional office activities. That responsibility, which will be exercised through chief medical officers or their designates, will include supervision of the care and treatment of beneficiaries so hospitalized in accordance with the terms of the agreement or contract; prevention of overhospitalization; procurement of services not included in the per diem rate of the agreement or contract; scrutiny of items listed in vouchers covering services rendered to determine if the services were necessary and duly authorized (see R. & P. R-6050 (B) (2)) and the fees charged conform with the contract or Schedule of Fees, Veterans Administration; indorsement of vouchers for hospital services; provision of clothing for such beneficiaries as are eligible, etc.

(C) Complaints regarding care and treatment of beneficiaries in other Federal hospitals will be referred, with full facts and recommendation, to the medical director, to be taken up by him with the Surgeon General, of the service concerned. Like complaints relative to State, municipal or civilian hospitals will also be so referred to the medical director. If the medical director concludes that a superintendent



of a contract hospital is not carrying out the terms of a contract, he will serve written notice upon such superintendent that the defective conditions must be corrected. If, within a reasonable time, the superintendent has not replied or, replying, refuses correction, the medical director will recommend to the Administrator, through channels, the cancelation of the contract, or stoppage of admissions to the hospital, without cancelation.

(D) Chief medical officers are authorized to make courteous inquiries of commanding officers of other Federal hospitals relative to apparently unnecessary prolongation of treatment in any case, statements by such hospital heads that a beneficiary's condition will not permit of his discharge or proposed transfer to a facility under direct and exclusive jurisdiction of the Veterans Administration, etc. Chief medical officers are similarly empowered as regards State, municipal or civilian hospitals, and may, in such instances, make personal contact with the hospitalized beneficiary, if considered necessary to satisfy themselves on the question at issue.】 (August 31, 1944.)

6528. 【COOPERATION WITH HEADS OF FEDERAL AND CIVILIAN HOSPITALS.--Managers of regional offices and facilities with regional office activities will furnish commanding officers of other Federal hospitals and superintendents of State, municipal or civilian hospitals utilized for beneficiaries of the Veterans Administration, such full information as will insure thorough mutual understanding and coordinated functioning. Especially important is the necessity of requiring that any unusual occurrence affecting beneficiaries of the Veterans Administration - assaults, accidents, elopements or injuries - be reported within 24 hours after the occurrence; and that notice sufficiently in advance of impending discharge be given when clothing is needed for such beneficiaries, or transportation is to be supplied, so that the beneficiaries may not be held unnecessarily in hospital until the needed service is rendered.】 (August 31, 1944.)

6529. 【VISITS TO CONTRACT HOSPITALS.--To ascertain if the terms of contract are being fully observed and that satisfactory care and treatment are being provided Veterans Administration beneficiaries, chief medical officers or physicians designated by them for this duty will make periodic visits, at intervals determined by them as appropriate, to all contract hospitals in their regional territory. The medical officer, in the course of this duty, will be tactful and courteous but vigilant in requiring full observance of the terms of hospital contracts. If unsatisfactory conditions of care and treatment, housing, meals, etc., are found upon such visits, which cannot be adjusted between the visiting physician from the Veterans Administration and the hospital head concerned, the chief medical officer will promptly submit a full report of the facts, with his recommendations, to the medical director, who will advise as to the further action to be taken. A brief written report of each visit to a contract hospital, including a statement of the conditions found and results obtained in the correction of any unsatisfactory conditions found, will be made by the physician who made the visit. Such report will be filed for one year in a manila folder, and then recommended for disposition as an inactive record.】 (August 31, 1944.)

6530. 【MAKING OF CONTRACTS WITH HOSPITALS.--Managers of regional offices and of facilities with regional office activities, with advice of chief medical officers, will invite such proposals from superintendents of State, municipal or civilian hospitals as will meet estimated needs of their territories. See R. & P. 8115 and 8118, Supply.】 (August 31, 1944.)

6531. [MINIMUM REQUIREMENTS FOR CONTRACT HOSPITALS.--(A) The following minimum requirements for any hospital with which a contract for treatment and care of Veterans Administration patients is proposed will be as follows:

(B) (1) A] hospital with at least one resident physician is preferable.

(2) A medical staff composed of men competent in their respective fields of medicine and actively meeting their responsibilities for the direction of the professional policies, for the medical work of the institution, and for the professional care of the patients in the hospital.

(3) Provision for examination and treatment by specialists.

(4) Resident trained nurses, not less than 1 for each 10 or any part of 10 bed patients.

(5) Facilities and personnel for the proper administration of dietetics.

(6) Periodic staff meetings to discuss (a) errors of diagnosis, (b) unsatisfactory results of operative or medical treatment, (c) autopsy.

(7) Adequate supply of nonprofessional personnel for all needs of hospital.

(8) Satisfactory fire protection for all classes of patients and perfect fire protection for bedridden patients.

(9) Satisfactory sanitary conditions as regards heat, light, sewage and garbage disposal, toilets, baths, water supply, laundering, cooking, dishwashing, refrigerating, handling and serving of food, care of clothing and valuables, cleanliness of buildings, etc.

(10) One hundred square feet of floor space for each bed and distance between beds 6 feet.

(11) All rooms and porches to be screened against flies and mosquitoes during the season,

(12) Satisfactory record of personal histories, physical examinations, all professional treatments, all clinical, serological, bacteriological or other laboratory work done for patients, also all X-ray, fluoroscopic and other special examinations made, progress notes, working and final diagnoses, and these records should be kept in a form permitting ready reference.

(13) Surgical operative facilities with sufficient equipment and competent organized personnel properly to meet all ordinary surgical emergencies and to perform all ordinary surgical operations in a manner and with results which meet general professional approval.

(14) Clinical laboratory facilities or definite arrangements for these facilities to properly carry out clinical, bacteriological, serological, X-ray and fluroscopic examinations.

(15) Physiotherapy, provision for special treatment, such as hydrotherapy and electrotherapy.

(16) Patients to be taught the elementary principles necessary to secure their cooperation in treatment.

(17) No charges to be made for patients absent from hospitals for more than 24 hours.

(C) ADDITIONAL REQUIREMENTS FOR TUBERCULOSIS HOSPITALS.-- (1) Resident physicians skilled in tuberculosis, if not living actually on the premises, to be available in 5 minutes or less (not less than 1 for 50 patients).

(2) Outdoor sleeping facilities, or in lieu thereof, provisions for unlimited ventilation of rooms.



(3) Suitable rules prescribed for conduct and published rules providing for a satisfactory regimen of treatment in tuberculosis hospitals.

(4) Satisfactory treatment conditions, including measures for enforcing suitable discipline and to prevent absence without leave and to prevent excessive exercise, whether from amusement or otherwise.

(D) ADDITIONAL REQUIREMENTS FOR NEUROPSYCHIATRIC HOSPITALS.--(1) Direction of the administration of the hospital and leadership in its medical work by physicians trained in the diagnosis and treatment of mental diseases.

(2) An adequate medical staff organized so that duties are divided in accordance with the training of its different members and with requirements of the clinical work.

(3) Regular and frequent conferences of the medical staff at which the diagnosis, treatment, and prognosis of each new case admitted are considered and at which cases about to be discharged are presented; training in psychiatry for new members of the staff being considered as a special object.

(4) The reception of all new cases in a special department or in special wards where they may receive careful individual study and where those with recoverable psychoses may receive continuous individual treatment.

(5) Classification of all patients with reference to their special needs and their clinical condition, such classification being flexible enough to permit frequent changes.

(6) A system of clinical records which permits study and review of the history of cases even after they have been discharged.

(7) When possible, the maintenance of a school of nurses under the direction of a supervisor of nurses, who should have not only training in general nursing but also special training in nursing patients with mental diseases.

(8) The employment of female nurses in all reception and infirmary wards.

(9) Liberal use of parole for quiet, chronic patients.

(10) Special provision for the tuberculous insane. (August 31, 1944.)

[6532 canceled August 31, 1944.]

## CONDUCT OF REGIONAL MEDICAL ACTIVITIES

6533. KEEPING IN TOUCH WITH WORKLOAD.--(A) Chief medical officers and their designates are required to be fully informed at all times as to the proportions and fluctuations of the regional patient load; to maintain that contact with beneficiaries which is necessary for an efficient conduct of the out-patient service; and to accomplish such economies in operation as are consistent with proper medical care and treatment.

(B) [See R. & P. 6450 for organization of out-patient activities and delegations of authority by the chief medical officer to the chief, reception-out-patient service or physician placed in charge of out-patient activities.]

(C) The functions hereinafter specified will have the continuous close supervision and direction of the chief medical officer. In addition, at quarterly intervals, he will survey the patient workload, to measure results and to formulate any changes in program he finds necessary. This continuous supervision and quarterly survey and inventory will include inquiry whether -

(1) Beneficiaries admitted to Army, Navy or Public Health Service hospitals, under blanket authority to the station from central office for emergency admissions only, can be transferred, the emergency having passed, to a facility under direct and exclusive jurisdiction of the Veterans Administration for any continued treatment that is necessary.

(2) Beds are available in facilities under direct and exclusive jurisdiction of the Veterans Administration for beneficiaries receiving authorized care and treatment in private hospitals.

(3) Results of treatment being rendered beneficiaries by designated physicians over relatively prolonged periods are satisfactory, with consideration of the advisability of discontinuance of treatment or admission of such beneficiaries to a facility for continuance of treatment. [ ]

(4) Beneficiaries receiving authorized hospitalization are receiving proper care; are not being overhospitalized; are being supervised as to passes and leaves of absence.

(5) Check-up of beneficiaries on self-medication for diabetes, asthma, etc., [ ] and supplies furnished them is being made, and proper supervision being given; patients prescribed narcotics [ ] are receiving only the required amount of such drugs and are under the necessary supervision; the prescribing of habit-forming drugs of any kind, including the barbiturates, is properly regulated.

(6) The services of nurses employed for the home treatment of beneficiaries need continuance.

(7) Careful check-up of supplies (drugs, dressings, etc.,) being furnished; of sickroom accessories; of orthopedic and prosthetic incidentals, such as stump socks, batteries for hearing devices, etc., is receiving attention.

(8) The needs of the regional territory are being adequately taken care of by the necessary number of competent, cooperative designated physicians.

(9) The designated physicians have been fully instructed as to their responsibilities and duties.

(10) Federal and civil hospital heads have been instructed as to rendition of reports and passes and leaves of absence; and are being [ ] supplied promptly with transportation requests, etc. (August 31, 1944.)



## OUT-PATIENT DENTAL ACTIVITIES

6535. CHIEF DENTAL OFFICERS.--In each regional office and facility with regional office activities, the out-patient dental activities will be administered by a chief dental officer under the [general supervision of the chief medical officer. A chief dental officer will be responsible to the chief medical officer] for the proper conduct of regional dental activities. In an office where the volume of dental activities does not warrant assignment of a chief dental officer, full time, the dental activities will be administered by a chief dental officer, detailed by central office from another station, for periodic visits of the requisite frequency and duration. (August 31, 1944.)

6536. FUNCTIONS OF CHIEF DENTAL OFFICERS.--[See Outline of Duties and Responsibilities of Field Personnel.] (August 31, 1944.)

[6537.] OUT-PATIENT DENTAL RECORDS.--(A) FILES.--The chief dental officer will maintain these files of dental records:

1. REGIONAL OFFICE DENTAL MASTER CARDS, FORM 2688.--Will be maintained in two sections, active and inactive, in each of which these cards will be filed alphabetically, according to names of patients. Individual cards will be kept in the active section from the date of application for relief until the case is completed or otherwise closed, when they will be transferred to the inactive section. Cases in which the relief is rendered in a Veterans Administration dental clinic will be considered as closed after the completed dental record chart is returned to the chief dental officer by the clinic and is filed. Cases in which relief is rendered by a designated dentist will be considered as completed when the case has been approved for payment and submitted for vouchering. If a beneficiary has previously had a dental examination or relief, and further examination or relief is authorized, a new master card will be executed. [ ]

2. EXAMINATION REPORTS.--In this file will be kept all incoming reports of dental examinations on Form 2570 revised, pending the receipt of the beneficiary's case file for rating or review. A follow-up every two weeks will be maintained on this file.

3. ABEYANCE.--The purpose of the abeyance file is to keep readily available such papers as may be necessary for reference pending time of closing cases. This file will contain such copies as may have been made of the Form 2570, and one copy of the letter authorizing treatment, for checking completed treatment. Copies of authorities for examination or relief of allied veterans will also be kept in the abeyance file.

4. MONTHLY REPORTS.--This file will contain copies of all monthly reports made to the central office, arranged by months, with the latest report filed in front. Copies of reports more than a year old will be reported for disposition as inactive records in accordance with the provisions of R. & P. 630-637.

(B) For active treatment and treatment abeyance files, see R. & P. 6234. (August 31, 1944.)

[6538.] FORM LETTERS.--The following form letters, procurable on requisition, will be used in the conduct of out-patient dental activities:

Form 2810, Instructions to Designated Dentists.

Form 2590, Authority to Designated Dentist to Render Dental Relief.

Form 2661, Authority to Veterans Administration Clinics or Designated Dentists for Oral Examination.

Form 2662, Notice to Claimant to Report for Oral Examination.

Form 2663, Authority to Clinics to Render Dental Relief.

Form 2664, Notice to Claimant of Allowance of Dental Relief.

Form 2665, Notice to Clinic of Disallowance of Relief.

Form 2666, Notice to Designated Dentist Regarding Disallowance of Relief.

The printed forms as listed will be limited in use to the original form, providing plain manifold carbon copies as required. (August 31, 1944.)

**[6539.] OFFICERS AUTHORIZING OUT-PATIENT DENTAL EXAMINATIONS.**--Dental examinations to be rendered on a fee basis will be authorized over the signature of the chief medical officer; those to be rendered in a Veterans Administration clinic will be authorized over the signature of the chief dental officer; except that when a full-time chief dental officer is not on duty, they may be authorized by the chief medical officer or his designate. Physicians in charge of the treatment of individual patients may request the chief dental officer to secure dental examinations to determine the necessity of adjunct dental relief. (August 31, 1944.)

**[6540.] CURTAILMENT OF DENTAL EXAMINATIONS.**--Out-patient dental examinations, particularly on a fee basis, will be held to a minimum consistent with actual requirements. Only in rare instances will a dental examination be necessary as a prerequisite to making a non-compensable dental rating [in World War I cases. However, in World War II cases, particularly when an informal application for treatment is received within a year of date of discharge, a dental examination will frequently be necessary.] Before a dental examination is authorized to determine the necessity of adjunct treatment, the service-connected general disease or injury will be ascertained, to obviate unnecessary dental examinations. (August 31, 1944.)

**[6541. PLACE OF DENTAL EXAMINATION.**--(A) Whenever economical and practicable, dental examinations will be made at field stations of the Veterans Administration in preference to utilizing the services of a designated dentist. A private dentist will be employed only when the examination cannot be made at a field station or by a designated dentist.

(B) Dental examination of Veterans Administration employees, to determine their eligibility for treatment as ex-members of the military or naval forces will, when practicable, be made at the field station in which they are employed. In regional offices without a dental clinic, the examination may be made through the medium of a designated dentist.] (August 31, 1944.)

## PROCEDURE IN AUTHORIZING DENTAL EXAMINATIONS

**[6543. LETTER OF AUTHORIZATION FOR EXAMINATION BY DESIGNATED DENTIST.**--This will be executed, in quadruplicate, on Form 2661 revised, and signed by the chief medical officer or his designate. The four copies of this form will be submitted to the finance officer for budget encumbrance, and subsequently disposed of as provided for Form 2590.] (August 31, 1944.)

**[6544. LETTER OF AUTHORIZATION FOR EXAMINATION IN VETERANS ADMINISTRATION CLINICS.**--If the examination is to be made in the dental clinic at the station where the authorization originates, no letter of authorization will be issued. If the examination is to be made in a clinic at a station other than the one where the authorization originates, an original and one carbon copy of Form 2661 revised, will be prepared. The original, signed by the chief dental officer or his designate will be forwarded to the



clinic which is to make the examination; and the carbon copy will be temporarily placed in the abeyance file, to be subsequently filed in the beneficiary's case file.] (August 31, 1944.)

6545. NOTICE TO CLAIMANT TO REPORT FOR ORAL EXAMINATION.--[When it becomes necessary to advise a claimant to report for oral examination, a Form 2662, Notice to Claimant to Report for Oral Examination, will be prepared in duplicate for the signature of the chief dental officer or his designate, the original to be mailed to the claimant, and the carbon copy to be filed in the case file.] (August 31, 1944.)

[6546.] TIME LIMITATION FOR DENTAL EXAMINATION.--Both Form Letters 2661 and 2662 contain a time limitation of thirty days in which the examination is to be made. Should the time limitation lapse, the authority for examination becomes void and a new authority will be necessary if the need for an examination still exists. This time limitation applies only to the examination, and not to any emergency relief to which the veteran may be otherwise entitled. (August 31, 1944.)

[6547.] DENTAL EXAMINATIONS IN FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--(A) When a beneficiary receiving authorized treatment in a Government facility other than one under direct and exclusive jurisdiction of the Veterans Administration, is entitled to Class I or Class II treatment (see R. & P. R-6123), the commanding officer of such facility will be requested to furnish report of a dental examination recorded on Form 2570 revised.

(B) When a beneficiary receiving authorized treatment in a civilian hospital is entitled to a dental examination, the superintendent thereof will be requested to have the examination made and reported on Form 2570 revised, by the dentist on duty at that hospital, if there be one. If no dentist is on duty the beneficiary, if his physical condition permits, will be referred to the nearest Veterans Administration clinic or, if necessary, to a designated dentist or private dentist, for the examination. If his physical condition does not permit of travel, a dentist from the nearest Veterans Administration clinic or, if necessary, a designated dentist or private dentist, will be authorized to make the examination at the civilian hospital. (August 31, 1944.)

[6548.] DENTAL EXAMINATION WHEN THE CLAIMANT IS IN A PENAL INSTITUTION.--In those cases where a dental examination is required of a claimant confined in a penal institution it will be obtained by arrangements made with the civil authorities in charge of the institution. If a dentist is on duty at the institution, examination by such dentist will be sufficient, provided he is willing to make the examination, and the report thereof is adequate for the purposes of the Veterans Administration. Fees for such examination will be in accordance with the Dental Fee Schedule (see Appendix). If dental examination cannot be obtained from the staff of the penal institution, arrangements will be made through the proper institution authority to have the examination made therein by a dentist detailed from the nearest station of the Veterans Administration, or by a designated dentist or private dentist. In no instance will a claimant confined in a penal institution be requested to report to a Veterans Administration clinic or designated dentist for examination. (August 31, 1944.)

[6549.] ROUTING OF REPORTS OF DENTAL EXAMINATIONS.--Upon receipt of a report of dental examination on Form 2570 revised, it will be forwarded directly to the chief dental officer to determine whether it is executed in conformity with instructions, and is in sufficient detail to meet requirements. If the report is lacking in any essential detail it will be returned for completion or correction. Pending final action on the case the Form 2570 revised, will be kept in the examination reports file. (August 31, 1944.)



## EMERGENCY DENTAL [TREATMENT]

6550. ADHERENCE TO DEFINITION OF EMERGENCY [TREATMENT].--Strict adherence to the definition of emergency dental [treatment] (R. & P. R-6124) will be expected. The fact that a tooth is diseased to such an extent as to require extraction is not in itself justification for its extraction as an emergency measure. It must be affirmatively shown that the condition for which alleged emergency treatment was given was such that it was causing appreciable pain or extreme discomfort, or was definitely and immediately endangering the life or health of the veteran. Designated dentists will make such affirmative showing by an appropriate statement under "General Remarks" on Form 2570. (October 16, 1945.)

6551. [VETERANS ENTITLED TO EMERGENCY DENTAL TREATMENT].--(A) Claimants on whom no dental rating has been made may be given any emergency dental [treatment] which may be necessary pending determination as to whether there is a service-connected dental condition.

(B) Those whose dental claims have been adjudicated under laws and regulations in effect prior to the passage of Public No. 2, 73rd Congress, will be entitled to emergency treatment only for teeth or conditions shown by the last rating to be service connected, and only until such time as the case is reconsidered under the provisions of R. & P. R-1104 to 1109, after which the service connection shown under that rating will govern.

(C) Those whose last dental rating shows no service-connected dental condition will not be entitled to emergency dental [treatment].

(D) Those whose last rating shows a dental disability incurred in service during a peacetime enlistment will be entitled to emergency treatment, for a service-connected condition, only if they were discharged from service on account of a disability incurred in line of duty, or are in receipt of a pension for a service-incurred disability.

(E) Those receiving vocational training [under Public No. 16, 78th Congress].

(F) Should application be made for emergency dental treatment at a station other than that at which the case file is located, the chief, dental [service] contacted will make every effort to ascertain the applicant's eligibility. Unless it can be definitely determined that he is not entitled, the applicant will be given the benefit of the doubt and the emergency treatment rendered at the station.

(G) In no event, however, will emergency dental treatment be authorized or approved on a fee basis until eligibility has been definitely established, as heretofore provided. (October 16, 1945.)

6552. EMERGENCY DENTAL [TREATMENT] PENDING APPROVAL OF ADJUNCT DENTAL TREATMENT.--Emergency dental [treatment], under consideration at the time of an examination to determine the necessity of adjunct dental treatment, or subsequent to that time, will not be approved unless the veteran is entitled under R. & P. 6551, or unless the treatment, rendered allegedly as an emergency measure, is subsequently approved as adjunct treatment. (October 16, 1945.)

6553. EMERGENCY DENTAL [TREATMENT] ON A FEE BASIS.--Designated dentists will be advised that the rendering of emergency dental [treatment] not previously authorized, will be upon their own responsibility and will not be approved unless entitlement is subsequently determined. All emergency treatment rendered without prior authority must be promptly reported and fees will not be paid for treatment not so reported or for treatment not subsequently approved. (October 16, 1945.)



6554. AUTHORITY FOR EMERGENCY DENTAL [TREATMENT].--When the rendering of emergency dental [treatment] is reported by a designated dentist, determination will be made whether the beneficiary is entitled thereto under the provisions of R. & P. 6551. If he is so entitled, or the treatment is subsequently approved as adjunct treatment, a [letter of authorization, Form 2590], will be issued to the designated dentist, stipulating the services authorized and the fees allowed. Such letters of authority will be prepared in quadruplicate for the signature of the chief medical officer or his designate, and will be disposed of as provided in R. & P. 6561 (B). (October 16, 1945.)

6555. PROCEDURE UPON RECEIPT OF REQUEST FOR DENTAL TREATMENT.--(A) Upon receipt of a request for dental treatment, either informal or on Form 2827 the case file of the applicant, if in possession of the station contacted, or the Regional Office Dental Master Card, Form 2688, will be consulted to ascertain if it contains a dental rating made under current laws and regulations. If no current dental rating is of record, the chief, dental [service] will present the case to the adjudication division for determination as to the service connection of the dental disability.

(B) In the event the current rating shows service connection for certain dental disabilities and there is no report of a recent dental examination available, one will be secured, and upon its receipt, necessary treatment for conditions shown by the rating to be service connected will be authorized.

(C) Should the applicant have a service-connected general disability wherein adjunct dental [treatment] might be indicated, an examination may be authorized, for further consideration.

(D) [Upon receipt of a request for dental treatment from a vocational trainee (Public No. 16, 78th Congress), dental examination on Form 2570 will be secured and the treatment authorized will be limited to that considered reasonably necessary to prevent the interruption of the authorized course of vocational training with consideration given to the training objective and the unexpired time of the approved training program.] At the same time the procedures prescribed in subparagraph (A) will be followed. Upon subsequent applications for treatment it will be authorized either as Class II or Class V, whichever will afford the greater benefit. (October 16, 1945.)

#### ADJUNCT DENTAL TREATMENT

6556. ELIGIBILITY FOR; PROCEDURE.--(A) When claimants or beneficiaries having a service-connected wartime disability, or persons who had peacetime service from which they were discharged for disability incurred in line of duty or who are in receipt of pension for a service-connected disability, have an associated dental condition which, in medical judgment, is materially affecting the basic service-connected disease or injury, adjunct treatment of such associated dental condition may be authorized.

(B) Ordinarily, consideration will be given to the necessity of adjunct treatment while such beneficiary is under treatment for his basic disease or injury on an out-patient basis, or at the time he is given a physical examination. However, consideration may also be given to adjunct dental treatment upon separate request therefor. In such cases the case file and medical file will be carefully reviewed before dental examination is authorized.

(C) After a chief, dental [service] has arranged such examination and the report thereof has been received, he will route it to the chief medical officer or his

designate, for opinion as to remediation of the dental condition, in the light of the examination report. If it is medical opinion that the dental condition shown is aggravating the basic service-connected disease or injury, and that adjunct treatment of the dental condition is indicated, the chief medical officer or his designate will affirmatively execute the appropriate certificate on the face of Form [10-2570, Dental Examination and Treatment Record]. If the medical opinion is that the dental condition needs no reparation as a part of the general treatment of the basic disease or injury, the said certificate will be correspondingly executed. In executing this certificate there will be shown only the service-connected disability, or closely related disabilities, for which adjunct dental treatment is being recommended. The certificate will be signed and dated, and the official designation of the signer will be added. This certificate will not be executed in whole or in part by personnel in the dental section of the station.

(D) Should the chief medical officer determine that adjunct treatment is not necessary no further action is indicated. Should his certificate indicate the necessity of adjunct treatment, the Form [10-2570] will be transmitted to the chief, dental service, for the prescription of the dental treatment necessary as an adjunct measure, which he will do by executing the second certificate on the face of the Form [10-2570]. (May 25, 1946.)

(E) The chief medical officer or designate will be responsible for the certification of the necessity of adjunct dental treatment and the chief, dental service for the prescription of the type of treatment indicated and its limitation to the actual requirements of the case. (October 16, 1945.)

(F) Cases in which any doubt arises as to the propriety of furnishing adjunct treatment or the type and extent of the treatment to be afforded will be referred to the [branch] medical director for his opinion. (May 25, 1946.)

#### PREScription OF DENTAL TREATMENT

6557. MODIFICATION BY CHIEF, DENTAL SERVICE.--(A) In prescribing dental treatment in Class I or II cases (see R. & P. R-6123 and R-6129), the chief, dental service or his designate may approve the treatment or prosthesis recommended on the report of dental examination, within the limits allowed by the dental rating; or may modify or curtail it so as to conform to governing provisions or to his professional judgment as to the requirements in the individual case.

(B) In Class III cases he will prescribe that treatment only which in his professional judgment will be of direct and material benefit in the treatment of the basic disorder.

(C) In prescribing dental treatment the chief, dental service, will delete with red pencil, on the report of examination, such operations and fees as are not required in the correction of the conditions covered by the rating in Classes I and II cases, or in the treatment of the basic disorder in Class III cases. (October 16, 1945.)

6558. [BRANCH OFFICE AUTHORITY FOR DENTAL SERVICE.--(A) The approval of the branch medical director or his designate will be secured for any special dental or oral operation or any special appliance, not listed in the Schedule of Fees, Dental, (Appendix, R. & P. 6015).



(B) The submission for approval of a special operation or appliance will furnish information as to the necessity therefor; a detailed description thereof; the fee which the dentist proposes to charge; and an expression of opinion as to whether the fee is reasonable and fair, based upon a comparison with fees ordinarily charged for similar services in that locality; the difficulty of the operation requiring special ability, and the reputation of the dentist for such ability. If the proposed fee is considered to be excessive, a fee for the services will be recommended by the submitting officer for approval. The dental examination and treatment record, and a copy of the current rating, if a Class I or Class II case, will be inclosed with the submission.] (May 25, 1946.)

6559. APPLICATION OF PROVISIONS OF R. & P. R-6029 (B) (2).--Approval of treatment under the provisions of R. & P. R-6129 (B) (2), will be based on the determination from a dental standpoint as to the necessity of furnishing a prosthetic appliance to replace nonservice-connected missing teeth in the opposing maxilla in order to make a satisfactory replacement of service-connected missing teeth. The matters of esthetics or convenience of the patient are not for consideration. Approval will not be given for a new appliance for the replacement of nonservice-connected missing teeth so long as the appliance previously furnished for replacement of service-connected teeth is functioning satisfactorily. (October 16, 1945.)

[6560 canceled May 25, 1946.]

#### PROCEDURE IN AUTHORIZING DENTAL TREATMENT

6561. PREPARATION OF LETTER OF AUTHORIZATION FOR DENTAL TREATMENT.--(A) After the chief, dental service, has prescribed the treatment which may be furnished in an individual case and secured [branch] office authority where required, he will complete the statement at the bottom of page three of Form [10-2570] revised, and sign it.

(B) [If the treatment is to be rendered by a participating dentist he will prepare a letter of authorization (an original and three carbon copies) on FL 10-13 (formerly Form 2590). All four copies will bear a procurement number. The original will be signed by the chief medical officer or his designate and forwarded to the selected dentist, together with the Dental Examination and Treatment Record, Form 10-2570.] (May 25, 1946.)

6562. LIMITATION OF FEES.--(A) In authorizing dental treatment to be rendered by [participating dentists, the letter of authorization will show the fee to be allowed for] the treatment and in no instance will an amount greater than that specified in the authorization be paid, except where additional authority has subsequently been given by a supplemental letter of authorization. (May 25, 1946.)

(B) [All dental treatment must be rendered in accordance with the specifications contained in Medical Form 2810, Instructions to Designated Dentists, as revised, and the fees allowed will conform to those provided in the Schedule of Fees (see Appendix) or as temporarily modified by central office instructions, except in special cases authorized under the provisions of R. & P. R-6131 and R-6132. The fees which will govern in the authorization of dental treatment will be those in effect on the date of the letter of authorization, notwithstanding that a different Schedule of Fees may have been in effect at the time of examination.] (August 31, 1944.)

[6563.] LIMITATION OF TIME FOR RENDITION OF RELIEF.--(A) Concurrently with authorization for dental relief to designated dentists, both the dentist and the applicant will be advised that the authorized relief must be completed within a certain specified time from date of authorization. Such time limitation will ordinarily be 60 days, except in cases in which, from their nature, it is apparent to the chief dental officer that more than 60 days will be required. In such cases he will specify the time he deems necessary.

(B) If the designated dentist finds that the authorized relief cannot be completed within the time specified, an extension may be granted by the authorizing officer upon receipt of request, accompanied by original letter of authorization, and by satisfactory evidence as to the necessity therefor. Such extension of time limitation will be indorsed on the original letter of authorization and on the copy retained in the abeyance file, and will be dated and signed by the chief dental officer. The finance officer will also be notified accordingly. It is not requisite that the extension of time limit be executed before expiration of the original time allotted. If, in those cases not completed in the specified time, the delay is caused by failure of the designated dentist to give prompt service, the case will be reauthorized, if possible, either to another designated dentist or to a Veterans Administration clinic, whichever is the more practicable and economical. (August 31, 1944.)

[6564.] CHANGE IN PRESCRIBED RELIEF.--(A) Authorized dental relief will be accomplished exactly as prescribed, and will in no case be changed without securing authority therefor from the authorizing officer.

(B) When it is the opinion of a designated dentist that a change in the prescribed relief is necessary, he will return the original oral examination blank and letter of authority to the regional office, with an explanation as to the necessity for a change in the authorized relief. The chief dental officer will determine whether the change may be made in accordance with current instructions; and, if so, approval of the change will be given by appropriate notation on the oral examination blank, initialed and dated by the chief dental officer. If the change in relief involves an increase in expenditure, a supplemental letter of authority covering the additional expenditure only will be issued. In no such case will the original authority be canceled and a new one issued. The supplemental authority will be signed and the various copies distributed in the same manner as prescribed for the original letter of authority in R. & P. [6561] (B).

(C) In those cases where the dental relief has been authorized to be furnished in a Veterans Administration clinic and a change in the relief as authorized is thought necessary, the dentist will indicate the change on the dental record chart under "Treatment indicated", and return the chart, with explanation as to why the change is necessary, to the chief dental officer. The latter, if he deems the change necessary, will approve it by placing his initials and date opposite the indicated change on the dental record chart. (August 31, 1944.)



[6565.] DENTAL RELIEF RENDERED PRIOR TO AUTHORIZATION.--Any dental relief, except approved emergency relief, rendered by a designated dentist prior to the date of letter of authorization will not be paid for by the Veterans Administration. Dental officers in Veterans Administration clinics will be held strictly accountable for rendering any dental relief, except approved emergency relief, prior to authorization. (See R. & P. [6551 and 6552.]) (August 31, 1944.)

[6566.] HANDLING OF COMPLETED BLANKS WHERE RELIEF HAS BEEN RENDERED IN A VETERANS ADMINISTRATION CLINIC.--Upon receipt of a dental record chart on which relief authorized by the chief dental officer has been rendered in whole or in part, he will check it to determine that the relief rendered is properly entered on page four of the form; that it is in accordance with the authorization; and that the dentist rendering the relief signed the certificate on the form. While it is not essential that the beneficiary sign the certificate that he has received the relief, etc., the certificate will be either signed by the beneficiary or the reason for failure to secure his signature briefly noted. Mentally incompetent patients will not be required to sign the certificate. If the dental record chart is incomplete or incorrect it will be either corrected by the chief dental officer, or returned to the clinic for the necessary additions or corrections, as may be appropriate. (August 31, 1944.)

[6567.] HANDLING OF COMPLETED BLANKS WHEN RELIEF HAS BEEN RENDERED BY A DESIGNATED DENTIST.--(A) When a designated dentist has completed the relief authorized, or where he ascertains that he will be unable to complete it, he will complete the designated dentist's certificate on the Form 2570. He will also ask the beneficiary to sign the patient's certificate that he has received the relief, and that it is satisfactory. While it is desirable that this certificate be signed, it is not essential. However, if the certificate is not signed the designated dentist will make a concise statement on the chart as to the reason therefor. In no case will a mentally incompetent patient be required to sign the certificate. The designated dentist will then promptly forward the form to the regional office which authorized the relief.

(B) Upon receipt of Form 2570 showing authorized relief rendered, the chief dental officer will check it to ascertain that the service is in accordance with the authorization and the fees; that the designated dentist's certificate is executed; and that the claimant's certificate is completed or its noncompletion explained. Should the fees charged be in excess of those listed under the authorization and fee tables, the chief dental officer will make appropriate correction. Should the relief be not completed in accordance with the prescription and authorization, the form will be returned to the designated dentist, if considered necessary, and upon its return appropriate action taken to bring it within the requirements. Should the chief dental officer have reason to believe that the authorized relief was not rendered, as shown by page four of the form, proper steps will be taken to have the beneficiary report to the nearest Veterans Administration clinic for examination and report of the relief actually rendered, provided no expense for transportation, etc., is incurred. Should the veteran be unable (either physically or financially) to report for examination, the matter will be referred to the manager for report to the medical and hospital service. (August 31, 1944.)

6568. TYPING OF ORAL EXAMINATION BLANKS.--To facilitate the preparation of vouchers and at the same time comply with the instructions relative to the typing of examination reports, duplicate typed copies of Form 2570 prepared by designated dentists in longhand will be made, one of which will be certified to accompany the original oral examination blank with the voucher, and the other filed in the beneficiary's case file. [ ] (August 31, 1944.)

## VOUCHERING ACCOUNTS OF DESIGNATED DENTISTS

6569. CERTIFICATION OF CHIEF DENTAL OFFICER.--(A) When the completed Form 2570 has been checked and all required corrections made, the chief dental officer will certify on page four of the form: "Checked and verified; recommended payment in the amount of \$\_\_\_\_\_"; and will add his initials and date. The original Form 2570 so executed, [ ] a certified typed copy thereof, and duplicate copies of Form 2504, [together with a single certified copy of letters of authorization] will be assembled, vouchered and submitted to the finance officer. [The voucher will bear reference to the number and/or date of the authorizations. (See R. & P. 4298, 4304 and 4311.)]

(B) If there appears on the fourth page of the Form 2570 a statement signed by the designated dentist that the dental relief has been rendered by him personally; that it is in accordance with the specifications and fee table in effect at the date of authorization; that the bill is correct and just; and that payment therefor has not been received, it will not be necessary to return the voucher to him for signature as the signature at the bottom of page four is sufficient. If the designated dentist's certificate does not include all of the foregoing information, the voucher will be returned to him for his signature in the appropriate space.

(C) Cases of allied ex-service men will be handled in a similar manner. (August 31, 1944.)

[6570.] LETTER OF SUSPENSION OR EXPLANATION.--Letters of suspension or requests for explanation of certain items received by the station from finance service, central office, in connection with dental vouchers, will be handled by the finance officer. Chief dental officers will supply, on request from him, any professional or technical information necessary in explaining discrepancies which are the subject of such communications. (August 31, 1944.)

[6571.] FINANCIAL RESPONSIBILITY OF AUTHORIZING OFFICERS.--Officials of the Veterans Administration who authorize dental relief at fees in excess of the schedule, without prior approval of the medical director; or who authorize services in excess of those actually required for correction of the dental condition covered by the rating in Classes I and II cases; or authorize services palpably unnecessary as Class III treatment will, - when a designated dentist has been paid for such authorized service and refuses refund, - be held financially responsible for refund to the Government for the services thus defectively authorized, in the estimated amount of overpayment. (August 31, 1944.)

[6572.] REFERENCE OF DIFFERENCE OF OPINION AS TO [ ] SCOPE OF RELIEF.--When there arise irreconcilable differences of opinion whether proposed relief is reasonably necessary to correct service-connected disability as shown by the rating in Classes I and II cases, the case will be referred to the medical director, for a determination of what is to be considered reasonably necessary. In cases where the authorizing officer is requested to refund monies expended for dental relief of beneficiaries (see R. & P. [6571].) and he is of the opinion that such a request is unfair or unjust, the case, with a statement from the authorizing officer setting forth his contention, will be submitted to the Administrator through channels, for his action. (August 31, 1944.)

6573. DISPOSITION OF OUT-PATIENT DENTAL RECORD CHART AND ORAL EXAMINATION BLANK.--All closed dental charts from out-patient clinics will be routed to the station having custody of the principal case file, for filing therein. A certified [ ] copy of all oral examination blanks from designated dentists will be disposed of in like manner. (August 31, 1944.)



[6574.] COMPLETION OF DENTAL RELIEF AUTHORIZED BY A FACILITY.--When from a facility, in compliance with R. & P. 6229, a beneficiary has been discharged with authorized adjunct treatment uncompleted, the chief dental officer of the station which has jurisdiction and to which the Form 2570 has been transmitted will take the necessary steps promptly to furnish the beneficiary with the approved out-patient treatment. The treatment approved by the hospital authorities will not be changed, unless absolutely necessary to accomplish the intended purpose. (August 31, 1944.)

[6575.] HOSPITALIZATION FOR DENTAL AND ORAL CONDITIONS.--Dental and oral diseases and traumata will only in rare instances be of a severity to require hospital treatment. Consideration should, however, be given to hospitalization of cases such as fractures of the bones of the face and acute infections. The chief dental officer will confer with the chief medical officer regarding such action in such cases. (August 31, 1944.)

#### DENTAL RELIEF IN THE INSULAR POSSESSIONS AND TERRITORIES

6576. REPORT OF EXAMINATION TO BE FORWARDED TO CENTRAL OFFICE.--(A) When an eligible ex-member of the military or naval forces of the United States, residing in the insular possessions or territories, applies for dental relief of a service-connected dental or oral condition, or adjunct dental treatment for another basic service-connected disease or injury, the station contacted will authorize a dental examination on Form 2661. A report of such examination on Form 2570, in duplicate, will be forwarded to the medical director, attention [out-patient and authorization division].

(B) If a Veterans Administration physician in the insular possession or territory concerned is of the opinion that adjunct dental relief is necessary, he will authorize a dental examination on Form 2661, a report of which on Form 2570, in duplicate, will be submitted to central office as in (A) hereof. He will make the statement of the physician in charge of the case as prescribed, on both copies.

(C) The dental [division] of the medical and hospital service, central office, will assume the functions ordinarily assigned to the chief dental officer of field stations having regional office functions, in handling these cases. (August 31, 1944.)

[6577.] APPOINTMENTS.--Patients in out-patient clinics who have been authorized dental relief will be given appointment slips, showing the day of the week, the date and the hour of their next appointment, as well as the name of the operator, if more than one operator is on duty in the dental clinic. The appointment slip will bear a notice to the claimant that if it is impossible to keep the appointment he is to notify the clinic to that effect at least 24 hours in advance of the appointment, except in case of an unforeseen emergency, in which case he will notify the clinic as long a time before the appointment as possible.

See. R. & P. R-6030 for action when a claimant or beneficiary will not cooperate. (August 31, 1944.)

[6578-6580 canceled August 31, 1944.]

## VOUCHERS FOR MEDICAL OR DENTAL SERVICES

**[6584.] PREPARATION, ENDORSEMENT AND CERTIFICATION.**--(A) Vouchers for all types of medical or dental services procured on a fee basis will be prepared and signed by the payee except [when a properly certified invoice is received, in which case the voucher may be prepared by the medical division of the field station which issued the authorization for the article or service, the certified invoice being then attached to the voucher.

(B) Vouchers related to medical or dental activities may include fee-basis examinations or treatments; nursing service in the home of a beneficiary; service of a laboratory]; treatment in civilian hospitals; any items of service not covered by the flat per diem rate of a contract hospital, or needed for a beneficiary in a non-contract hospital (e.g., private room, special nurse, expensive drugs or serums, blood transfusions, surgical operation, assistant to an operating surgeon, anesthetist, X-ray or other laboratory service, etc.); and services of an attending physician or consultant.

(C) Vouchers covering travel expenses of claimants or beneficiaries and their attendants, including travel authorized subject to reimbursement for expenses shown by receipts, will be prepared by the supply division [of the station, and signed by the payee. Vouchers covering authorized ambulance transportation, whether contract or otherwise, and vouchers related to orthopedic or prosthetic appliances, will be prepared and signed by the payees, except when, as provided in (A), a properly certified invoice is received. In the latter event, the voucher may be prepared by an employee of the supply division of the field station at which was issued the authorization and that employee will attach the certified invoice to the voucher.

(D) For endorsement and certification of vouchers related to medical or dental activities, see Finance Procedure.]

See R. & P. 4202 and 4298-4316, procedure in preparing vouchers for medical services and Decision of Questions of Fact and Law, Form 2504. (August 31, 1944.)

**[6585.] SANITATION OF REGIONAL OFFICES.**--The chief medical officer, or a physician designated by him, will be responsible for the sanitation of a regional office. Sanitary inspections will be made once weekly, or oftener if necessary. Attention will be given to illness of employees, especially in relation to communicable diseases; cleanliness of floors, walls and ceilings; ordered and cleanly arrangement of desks, cabinets, files, etc.; condition of plumbing; care of toilet rooms; heating and ventilation of the offices; disposal of soiled dressings, etc.; fly prevention; cleanliness of smocks or uniforms worn by personnel; care of instruments, supplies, etc. Prompt correction of any disorderly, unclean or insanitary conditions noted will be ordered by the sanitary inspector who will report to the manager, through the chief medical officer, any failure to comply. (August 31, 1944.)

**[6586. REPORTS OF OUT-PATIENT ACTIVITIES.**--The following reports of out-patient activities will be submitted as provided:

(A) To the budget officer and chief of statistics, monthly - Form 2565, Monthly Report of Out-patient Service, Regional Offices and Facilities; Form 2612, Monthly Report of Physical Therapy; Form 2620, Clinical Laboratory Report; Form 3408, Social Workers Report; Form 2587, Monthly Report of Dental Operators; Form 2587a, Monthly Report of Dental Clinics; Form 2685, Report of X-ray and Electrocardiographic Activities.



(B) To the medical director, semi-annually - changes in list of designated physicians and designated dentists (i.e., resignations, deaths, new appointments, fee or part-time); annually, Form 2623, confidential efficiency report on professional and semi-professional personnel engaged in medical activities; annually, medical research report; irregularly as occasioned, Form 2623a, Experience, Qualifications and Preference Statement by Full-time Physician or Dentist, new appointees; irregularly as occasioned, Form 2633, Report of Assaults, Accidents, Injuries and Elopements of Beneficiaries; to other facilities, irregularly as occasioned, Form 2681, Survey of Home Conditions of tuberculous patient proposed for statutory discharge from hospital under R. & P. 6151.] (August 31, 1944.)

【6590-6631 canceled August 31, 1944.】

【6640 canceled August 31, 1944.】

## FACILITIES AND REGIONAL OFFICES; PROCEDURE IN COMMON AND IN COOPERATION

### EFFICIENCY REPORTS

6700. CONFIDENTIAL EFFICIENCY REPORTS.--(A) Completed Form 2623, confidential efficiency report; will be submitted to the medical director, at the end of the fiscal year, to cover the following personnel in facilities and regional offices: All full-time physicians and dentists, including those occupying medical administrative positions (except managers, chief medical officers, and physicians assigned to disability rating boards); consultants and physicians, part-time or fee-basis, on visiting staffs (but not including designated physicians and designated dentists, part-time or fee-basis, rendering territorial services for regional offices and facilities with regional office activities); pharmacists, pharmacists' assistants; laboratorians, laboratory assistants; oral hygienists, dental assistants, dental mechanics; nurses, nursing assistants, dietitians; occupational therapy aides, physical therapists, attendants in physical therapy and occupational therapy; recreational aides; librarians and social workers; orthopedic mechanics, bio-chemists, pharmacologists, medical photographers, medical statisticians, physical directors, recreational aides.

(B) Confidential efficiency reports on new personnel will be submitted not later than five months after the date any such employee entered upon duty, accompanied by a recommendation as to the retention of such employee. The same procedure will apply to employees who have been reinstated in the service. When an employee is transferred to another station of the Veterans Administration, a confidential efficiency report covering the period of his or her service up to the date of transfer (and from the preceding June 30 if Form 2623 had been submitted at that annual period) will be submitted; while the station to which he or she is transferred will submit a confidential efficiency report on the transferred employee as of the succeeding June 30. When an employee has been assigned to new duties at the same station, a Form 2623 reflecting his or her efficiency in the new duties will be submitted not later than six months after he or she enters upon them.

(C) Reports on a clinical director will be prepared by the manager or chief medical officer; on a chief nurse, chief dietitian, chief aide, chief physical therapist, and heads of library and social work by the clinical director or chief medical officer; on the visiting staff, chiefs of services or units, chief dental officer, pharmacist, pharmacist's assistant, laboratorians, orthopedic mechanic, bio-chemist, pharmacologist, medical photographer, medical statistician, by the clinical director or chief medical officer; on full-time physicians by their chiefs of service or clinical director; or dentists, oral hygienists, dental assistants and dental mechanics, by the chief dental officer; on nurses, nursing assistants, dietitians, aides, physical therapists, librarians and social workers, by the head of such activities or persons authorized to do so in the absence of such heads; laboratory assistants by the chief, laboratory service. Confidential efficiency reports so executed will be forwarded to the clinical director or chief medical officer for approval and subsequent transmittal to the manager, through whom the reports will be submitted to the medical director.

(D) Confidential efficiency reports on chief medical officers will be prepared by the medical director.



(E) For officers of the medical and dental corps, War Department, on active military duty and assigned to the Veterans Administration, Efficiency Report, WD AGO Form 67 will be executed, in accordance with instructions, besides Veterans Administration Form 2623, and Standard Form 51, C.S.C. Report of Efficiency Rating, will be submitted, as provided, for all civilian field personnel.] (September 13, 1944.)

6701. EXPERIENCE, QUALIFICATIONS AND PREFERENCE STATEMENT.--(A) Form 2623a, [the experience, qualifications and preference statement,] will be executed, in duplicate, once only, viz., when a full-time physician or dentist has completed his probational [or trial] period and has entered upon a permanent assignment to duty.

(B) The questions on the front of Form 2623a, and the description of qualifications under item 23 on the back will be answered by the physician concerned, who will sign his name and title opposite the first signature space, and submit the statement so executed to his immediate superior (e.g., chief of service). The latter will transmit it, with any comment desired, to the clinical director or chief medical officer, who will add his certification above his signature at the bottom of the form. The original will be forwarded to the medical director who, after its consideration, will refer it for filing in the central office personnel file of the physician or dentist. The clinical director or chief medical officer will have the carbon copy filed in the station's personnel file related to the physician or dentist. (September 13, 1944.)

[ If ]

## RELATIONS WITH THE MEDICAL AND ALLIED PROFESSIONS

[6704.] AFFILIATION WITH SOCIETIES.--(A) A cooperative relationship between physicians and dentists of the Veterans Administration and individual practitioners and societies of their professions is mutually advantageous and desirable. Participation in scientific programs; and arrangements for joint meetings with county societies, are to be encouraged. Clinical directors and chief medical officers will stimulate such interests and activities.

(B) Opportunity will be taken, in such contacts with individual practitioners or groups, to acquaint them with the activities and accomplishments of the Veterans Administration and the legislation governing the extension of medical benefits. Visits of practicing physicians and dentists to field stations should be encouraged, so that they may observe the proportions of the problem of veterans' relief, and the manner in which it is handled.

(C) Physicians and dentists, full-time, of the Veterans Administration, desiring to attend meetings [(national, regional or State)] of associations for the promotion of medical science, will, at a time sufficiently in advance, submit their requests to the medical director, through channels. If they purpose to present a paper or to join in a discussion at such meeting, they will submit a copy of the proposed paper or a summary of the proposed discussion with their request for leave to attend the meeting. The paper or discussion will be subject to approval by the medical director. Authority to attend the meeting, upon official leave, at no expense to the Government, will be accorded by the medical director, on approval by the Administrator. Upon return to his station, the physician or dentist concerned will submit to the medical director a sufficiently full report of the transactions of the meeting, with particular reference to his participation in the program, and to any topic brought up which relates to the activities of the Veterans Administration.



(D) [Nurses, dietitians, librarians, social workers, occupational therapy aides and physical therapists, laboratorians, oral hygienists, dental assistants, and pharmacists, desiring to attend meetings of recognized professional societies, will be subject to the provisions of (C) hereof.] (September 13, 1944.)

## TRAINING OF PHYSICIANS

[6707. ASSOCIATE PHYSICIANS.---Except when exigencies of the service demand modification of the policy, as determined by the medical director, associate] physicians will be required, before assignment to duty, to attend a four-months course of instruction, in medical and medical-administration subjects, at facilities designated by the medical director. The personal and professional qualifications of such physicians will be closely observed by the chief medical officer or clinical director of such facility, who will bring to their attention any lack of interest or cooperation or deficiency in qualifications, with a caution that acceptance for permanent appointment will be conditioned upon full correction of fault. At the termination of the course a report of the personal and professional qualifications of each trainee, and his relative standing in the course, will be submitted to the medical director by the manager, with appropriate comment or recommendation as to fitness of the trainee for retention in the service. (September 13, 1944.)

[6708. POSTGRADUATE COURSES.---Except when exigencies of the service demand modification of the policy, as determined by the medical director, there will be arranged, annually, for full-time physicians occupying positions in central office or field stations, subject to prior allotment of funds necessary to cover all incidental expenses, two postgraduate courses each of four months duration, at diagnostic centers or other selected stations] of the Veterans Administration. The medical director, subject to approval by the Administrator, will set the dates and centers for these courses, decide the number of students for each class, and select the physicians who will attend. He will also request the chairman, board of veterans appeals, directors of services concerned, and managers of field stations to nominate physicians desiring to take such postgraduate training. Managers will consult their chief medical officers or clinical directors in tendering these nominations, which must be made with the interests of the service primarily in mind. (September 13, 1944.)

[6709. POSTGRADUATE TRAINING IN SPECIALTIES.---When required by the needs of and with regard to the exigencies of the service, the medical director, subject to approval of the Administrator, may detail selected full-time physicians, dentists, or laboratorians for intensive postgraduate training in the administration of anesthetics, pathology, roentgenology, dental surgery, laboratory technique, newer therapeutic methods, or other special branches of medicine or surgery. Such courses, of limited duration, will be given at selected facilities under direct and exclusive jurisdiction of the Veterans Administration.] (September 13, 1944.)

6710. POSTGRADUATE TRAINING AT OTHER THAN VETERANS ADMINISTRATION FACILITIES.---[When exigencies of the service permit, and] under section 33, Act of July 2, 1926, amending the World War Veterans' Act, 1924, as continued in force by section 7, Title I, Public No. 2, 73d Congress, which authorizes the Administrator, in his discretion, to detail not more than 2 per centum of the professional personnel of the Veterans Administration to attend professional courses conducted by agencies other than the Veterans Administration, provided that such instruction shall not be outside of the continental limits of the United States, the medical director will



consider requests from full-time physicians or dentists to attend courses of post-graduate training at schools, or at hospitals or clinics other than those under direct and exclusive jurisdiction of the Veterans Administration. Such requests must be forwarded through channels, with indorsements by the manager and chief medical officer of the station. When grant of official leave or expense to the Government is involved in such requests, the authorization of the Administrator will be required. (September 13, 1944.)

[ ]

[6712 and 6713 canceled September 13, 1944.]

## COOPERATION WITH PUBLIC HEALTH AGENCIES

6714. KNOWLEDGE OF PUBLIC HEALTH LAWS AND ORDINANCES; ASSISTANCE TO AUTHORIZED OFFICIALS.--(A) Managers, [ ] chief medical officers [and clinical directors will inform themselves and their medical staffs regarding State [and county] laws or municipal ordinances governing public health, and will be prepared to give the fullest possible cooperation to authorized health officers, including coroners, particularly in furnishing data in reportable diseases. Should it be found that any such State [or county] law or municipal ordinance conflicts with a provision of the Regulations and Procedure, Veterans Administration, the manager concerned will report the circumstances to the medical director for instructions how to proceed.

(B) [Information required under State or county laws or municipal ordinances relative to a beneficiary of the Veterans Administration suffering from a reportable disease will be furnished by the chief medical officer or clinical director of the regional office or facility concerned. Whether the beneficiary have residence in the State wherein the reporting field station is located, or in any other State, the report will be sent to the health department of the State wherein the station is located. The head of that department, through an interstate reciprocity agreement for such interchange, will forward the report to the health department of any other State where the beneficiary has residence, and the head of the latter department will notify the health officer of the county of residence.

(C) The report will be forwarded in duplicate, so that the State health officer may send a copy to another State, or to the health officer of a county in his own State, as indicated. The data reported will conform to the State requirements as to record of diagnosis, symptomatology, physical findings, etc., and will incorporate information as to the point whence the beneficiary had come to the field station of the Veterans Administration and is proceeding upon completion of his examination or treatment. If it is ascertained that change of address is intended (in regard to State, county, city or town), that information will be supplied. The number and ages of the members of the beneficiary's household will be recorded.

(D) Reports relative to hospital patients will be rendered upon discovery of the condition, and upon each readmission. Readmission reports will be identified as "repeat report", with the number of the readmission, e.g., "second", "third", etc. The clinical clerk will prepare the report, under the supervision and for the signature of the chief medical officer or clinical director.

(E) Reports relative to out-patients will be submitted whenever the condition is discovered, with "repeat report" to be rendered whenever the patient reappears for examination or treatment, except that out-patient visits for pneumothorax re-fills need not be reported. A designate of the chief medical officer may prepare the report for him, in out-patient units.



(F) When a beneficiary with a reportable disease is transferred between facilities under the direct and exclusive jurisdiction of the Veterans Administration, a report of the action will be made by the transferring facility to the health officer of the State in which that facility is located: and the receiving facility, if in another State will, upon arrival of the patient, report the transfer to the health officer of the State in which the receiving facility is located.

(G) When a reportable beneficiary is transferred from another Federal or contract hospital to a facility under direct and exclusive jurisdiction of the Veterans Administration in the same State, the chief medical officer of the transferring station, or his designate, will report the action to the health officer of the State. If the transfer be made to another State, the same course will be followed; but the chief medical officer or clinical director of the receiving facility will report arrival of the transferred patient to the health officer of the State in which the receiving facility is located.

(H) The reporting of beneficiaries with active tuberculosis who leave hospitals against medical advice, or absent themselves without leave, or the reporting of out-patients with active tuberculosis who fail to appear for required examination or treatment, is a particular necessity.

(I) Social workers are not relieved, when such reporting is attended to, from the responsibility of utilizing such public and private community resources as are available, to procure prompt examination and necessary treatment of members of the beneficiary's family; and to obtain for the beneficiary such help and supervision as the community affords, as well as encouragement to secure rehospitalization at the first opportunity. The object is not merely to help the patient conserve the progress made through expensive examination and treatment, but also to protect the health of families and the public.] (September 13, 1944.)

[6715 canceled September 13, 1944.]

#### RELEASE OF MEDICAL INFORMATION

[6717. INFORMATION TO PRIVATE PHYSICIANS AND DENTISTS.--A chief medical officer or clinical director may furnish a private physician or dentist, upon request, with a summary of the medical history, diagnosis, symptoms, physical findings and treatment of a beneficiary who had been examined or treated by the Veterans Administration, and who is receiving treatment of the private physician or dentist, when the chief medical officer or clinical director is satisfied that such information will be of benefit to the veteran. No charge will be made for such summary which, however, will be supplied only under these conditions: that the physician or dentist submit a written authorization, signed by the beneficiary for release of the information, and that the physician or dentist be cautioned that the data are to be regarded as privileged, and are not to be divulged to any person other than the beneficiary, and then only as a professional necessity. If any sufficient authorization for release of medical information, duly signed by the beneficiary, accompany the private practitioner's request, the data will be furnished without requiring execution of Form 3288, Request for and Consent to Release of Information from Claimant's Records. If the private practitioner does not submit an authorization of any sort, or if that submitted is unsatisfactory, a copy of Form 3288 will be mailed with instructions to have it executed by the beneficiary and returned to the station concerned. Should the beneficiary request that the data be supplied directly the beneficiary



will be informed that such request cannot be complied with; but that, if he will execute and return Form 3288 (which will be enclosed), the necessary data will be sent directly to the physician or dentist named, at the address supplied, upon the returned form. The latter action will then be taken by the station concerned. See also R. & P. 310-338 and 1037-1044 relative to release of information.] (September 13, 1944.)

**[6718.] INFORMATION TO HOSPITAL HEADS.--**(A) When the superintendent of a private or municipal hospital for general medical or surgical patients, or the superintendent of a State or city sanatorium for tuberculous patients requests information relative to a patient in any such hospital who had previously received care and treatment through the Veterans Administration, the office or facility contacted may supply the summary mentioned in R. & P. **[6717]** under the conditions therein stipulated.

(B) When such request is received from the commanding officer of a Federal hospital **[the summary mentioned in R. & P. 6717 may be supplied without prior consent of the patient to release of the information.]**

(C) When such request is received from the superintendent of a State hospital for psychotic patients, or from a commissioner, department of mental hygiene, etc., the summary mentioned in R. & P. **[6717]** may be supplied under the conditions provided in (B) hereof. Reciprocal service will be required from such hospital **[or department] heads.** (September 13, 1944.)

**6719. INFORMATION TO FEDERAL AGENCIES.--****[Data as to the physical or mental condition of claimants or beneficiaries of the Veterans Administration may be disclosed to responsible officials of Federal agencies, upon request, without obtaining prior consent of the claimants or beneficiaries. Information so supplied will be marked "Confidential; official use only".]** (September 13, 1944.)

**[6720. INFORMATION TO INSURANCE COMPANIES.--**(A) (1) Forms of life or accident insurance companies, calling for data as to the nature, probable duration of a disease or injury, etc., of an insured person] who is receiving treatment in a Veterans Administration facility, may be filled out by the patient's ward physician, without charge for the service, subject to the following conditions:

(2) Whenever, on such form, there is a request for opinion whether the **[insured is totally]** or permanently totally disabled, the physician executing the form will not answer such question, because of its administrative implications to the Veterans Administration and because determination on this point will be held to rest with the company's physicians, to be made from the diagnosis, symptoms and findings reported on the form.

(3) If the patient or **[the patient's representative had received the form and asked that it be executed, the ward physician will do so and]** will mail it to the company in a stamped envelope furnished by the patient, his representative, or the company.

(4) If the form was received by the manager or other station employee, permission in writing to release the information will be **[obtained (Form 3288) from the patient, if mentally competent, or if mentally incompetent from the patient's guardian or nearest relative, if he is incompetent. If permission be so given, the insurance form will be executed by the patient's ward physician and returned to the company, using return postage if inclosed by the company, or stamp paid for or furnished by the patient or patient's representative. If the receipt of such forms from a company is frequent, with habitual failure to inclose return postage, the company will be informed that return stamped envelopes must be provided for all future forms that are submitted for execution.]**



(B) [A beneficiary under treatment in a Veterans Administration facility may, upon request of an insurance company, be examined by a physician representing the company, when such examination, in the opinion of the chief medical officer or clinical director, will not be detrimental to the patient's physical or mental condition, when it is made in the presence of a Veterans Administration physician, and when such examination is acceptable to the patient, if mentally competent, or if mentally incompetent, to the patient's guardian or nearest relative.

(C) (1) General waivers or blanket authorizations executed by beneficiaries of the Veterans Administration authorizing release of medical information, including copies of records, to insurance companies, will not be considered to justify disclosure of such data under the terms of Veterans Regulation No. 11. It will be required that the companies, in such instances, submit Form 3288, executed by the beneficiary of the Veterans Administration concerned, consenting to release of and defining the nature of the data to be supplied the insurance company. In furnishing copies of records, the provisions of R. & P. 324-327 will guide.

(2) When forms of commercial insurance companies, relative to proof of death, etc., are received by field stations for execution after the death in a facility of an insured patient or member, the consent of the personal representative (administrator or executor of the estate of the decedent) to release of the information will be obtained. If such forms are received by the facility in which the death occurred and that facility has authority to adjudicate death claims or if the forms are received before the case file, clinical records and correspondence files had been forwarded to that office having authority to adjudicate death claims, the forms will be executed. If the insurance forms are received subsequent to the forwarding of files and records, the forms will be promptly transmitted to that office to which the records had been forwarded, and they will be executed by a physician in that office upon the basis of the recorded data. In returning the executed form to the insurance company, it will be briefly explained that execution by the attending physician was not practicable, but was truly made from Veterans Administration records. The forms will be completed in central office by the insurance service.

(3) When an administrator or executor of the estate of a deceased beneficiary of the Veterans Administration has not been appointed, or when no action is contemplated looking to appointment of an administrator or executor, consent to release of medical information will be obtained from the surviving spouse or children of the deceased person or, if unmarried, from either parent. If none of the persons enumerated is living or can be located, a brother, sister or other next of kin may give consent.

(4) If any person enumerated in (3) refuses consent to release of medical information, and the information desired by the insurance company is, in the opinion of a chief medical officer or clinical director sufficiently conveyed in the death certificate, it may be suggested to the company that the desired information might be accessible through that public record.] (September 13, 1944.)

[6721. INFORMATION TO PUBLIC ASSISTANCE AGENCIES.--(A) (1) Section 401 et seq. Title IV, of the Federal Security Act, August 14, 1935, as amended, provides that State agencies will be set up to administer funds furnished jointly by the Federal and State Governments, to be expended for old age assistance, and to dependent children and to the needy blind, vocational training and education..



(2) Upon request from any tax-supported welfare agency of a State, society, city or town, the date of enlistment and the date and character of a veteran's discharge from active service, if available, may be furnished. The available medical history, physical findings, symptoms and diagnosis of a beneficiary of the Veterans Administration may be furnished, provided that the Veterans Administration beneficiary authorizes release of such information by execution of Form 3288, Request for and Consent to Release of Information from Claimant's Records. If the veteran be mentally incompetent and a fiduciary is acting, the latter will execute this form. If no fiduciary has been appointed, there may be furnished, without requiring the consent of the veteran, a similar report with the stipulation that it is for the confidential use of the agency alone and not for transmittal to others. However, should there be reason to believe in any particular area that the medical or social data relating to an incompetent veteran will not be treated as confidential, the data will not be released until the welfare agency furnishes an authorization for release of such information signed by the veteran's duly authorized representative.

(B) Summaries of medical data for release to welfare agencies will be prepared for signature of the chief medical officer, clinical director or designate of either, preferably by a social worker.

(C) Whenever the assistance of a tax-supported social agency or an American Red Cross chapter is administratively desired for cooperation with the Veterans Administration in social work, the necessary medical and social report data in the records of the Veterans Administration may be supplied, marked "confidential", to such agencies.] (September 13, 1944.)

6722. [INFORMATION TO BENEFICIARIES, THEIR REPRESENTATIVES AND PROSPECTIVE EMPLOYERS.--(A) See R. & P. 312, which provides that information from the records of the Veterans Administration may be disclosed, by the regional office or facility with regional office activities in possession of the case file, to the beneficiary or the duly authorized representative of the beneficiary, as to matters concerning the veteran alone, when such disclosure will not be injurious to the veteran's physical or mental health. If the veteran be dead, matters concerning the deceased may be disclosed to the surviving spouse, children or next of kin, provided such disclosure will not injure "the mental or physical health of the person in whose behalf information is sought, or cause repugnance or resentment toward the decedent." While the correspondence in connection with such requests for information will be conducted by the adjudication officer of the field station concerned, he will, as provided in R. & P. 316, obtain from the chief medical officer of the regional office or facility with regional office activities, or from the manager in other facilities, the determinations whether release of the medical information will be prejudicial to the mental or physical health of the inquirer, or would excite repugnance or resentment, etc., as provided above. This responsibility will be exercised by medical officers with circumspection and the best judgment in every case. It is not obligatory to release all or any medical information; the disclosure is to be conditioned upon the nature of the information and its estimated effect upon the inquirer. Such information as it is judged advisable to disclose may be softened by intelligent generalizations (e.g., "a disorder of the nervous system", instead of naming the disease). Technical terms not comprehensible to the average layman will be avoided.

(B) (1) Besides medical information imparted as in (A), managers, chief medical officers, clinical directors, chiefs of services, ward physicians, the chief, reception-out-patient unit or his subordinates in out-patient treatment will have to deal directly with patients or their relatives in the matter of disclosing medical information regarding a patients' condition.



(2) In discussing the medical aspects of a case with the patient's relatives, the physician will be guided by the precautions outlined in (A).

(3) To secure their cooperation during hospital or out-patient treatment and, upon their discharge therefrom, to conserve the gain they had made during treatment and to attain the objective of a maximum medico-social rehabilitation, it is important that patients be given an understanding of their health problem. In conveying this, the principle stated in the Manual for Medical Examiners (page 6) will guide:

"What is disclosed to a beneficiary by a physician who is conducting his medical treatment, regarding the identity or relative gravity of the beneficiary's disease, will be imparted solely with the purpose of securing the patient's cooperation in his treatment; and, even then, the specific medical treatments given to a beneficiary must be disclosed with that tact, discretion, judgment, and sensing of the temperament, intelligence and motives of the patient that is expected in the relations of a physician with a patient in the private practice of medicine."

(4) The maximum medico-social rehabilitation mentioned in (3) comprehends fitness for vocational training for those entitled thereto or suitable employment. Patients who are proposed for those objectives must understand their physical limitations and the due care within sensible bounds that they must observe. It will be the policy to provide opportunities for patients to receive vocational advisement prior to their discharge from hospital. This counseling service will be rendered through cooperation between facility personnel and vocational advisers according to the procedure outlined in the Manual of Vocational Advisement, Veterans Administration.

(5) In advising patients as to employment, it is inadvisable to state directly that their condition forbids return to a formerly held occupation; it is better to suggest the working conditions which they should avoid. Physicians of the Veterans Administration will not make any statement to the patient or others relative to the extent or permanency of the patient's disability or degree of employability. This policy is necessary first, because such an opinion involves administrative decisions officially reached, not by the physicians treating the patient, but by rating agencies; and second, because such decisions, so far as business organizations are concerned, rest with the physicians of those organizations. Requests from prospective employers for an explanation of the conditions that caused a veteran's discharge from the armed forces because of disability will be answered with care, and only with the veteran's consent (Form 3288). The object will be to assist the prospective employer in arranging a suitable placement. Technical diagnostic terms may be misconstrued; the condition will be explained in simple words, indicating the patient's limitations, the precautions to be observed, and the remaining capacities. The Veterans Administration in such instances, has a responsibility both to the veteran to help guard against placement in a situation dangerous to health, and to the employer, whose cooperation in the proper placement and reestablishment of the veteran it is desirable to foster.] (September 13, 1944.)

[6723 canceled September 13, 1944.]

6724. [SAFEGUARDING INFORMATION OF MILITARY VALUE.--For the duration of the war proper precautions will be taken at every field station of the Veterans Administration to prevent the release of any information - to any agency, person or group - through whom that information might filter through to enemies of the United States. For detailed instruction, see R. & P. General.] (September 13, 1944.)



6725. PUBLIC MEDICAL ADDRESSES; PUBLICATION OF PROFESSIONAL PAPERS.--(A) See R. & P. 133, regarding radio broadcasting; also R. & P. 112 (A). See R. & P. 115-131, regarding press releases relative to activities of the Veterans Administration. Complete papers or summaries of discussions which are to be read at meetings of medical or dental societies, or at meetings of societies of nurses, dietitians, librarians, social workers, [physical therapists] or occupational therapy aides, pharmacists, laboratorians, etc., must be submitted, for prior approval, to the medical director at a time sufficiently in advance of such meeting.

(B) All full-time physicians and dentists of the Veterans Administration will be expected to submit, annually, at least one paper on a medical or dental subject, or on a medical administration subject unless this requirement be waived in any individual case by the medical director. Such papers, addressed to the Editor, Medical Bulletin of the Veterans Administration, will be routed by the author through the chief medical officer or clinical director, and will be approved by such officers before forwarding to central office.

(C) Papers prepared by full-time physicians, [dentists or other employees engaged in medical activities of the Veterans Administration,] for proposed publication in a journal other than the Medical Bulletin of the Veterans Administration, will be submitted to the medical director, through the chief medical officer or clinical director of the station, for grant of permission for publication. If approval is given, the article, when published will carry a footnote, "Published with permission of the Medical Director, Veterans Administration, who assumed no responsibility for the opinions expressed or conclusions drawn by the author." However, in papers prepared by or under direction of the medical director containing statistical or other data and interpretive opinion, for which the medical director deems it proper to accept responsibility, this foot-note may be omitted. Papers prepared by consultants or attending specialists, part-time or fee-basis, for publication in a journal other than the Medical Bulletin of the Veterans Administration, when referable to patients of or policy or procedure of, the Veterans Administration, will be subject to the foregoing requirements of this subparagraph. Such papers of such consultants or attending specialists, when not dealing with patients of, or policy or procedure pertaining to the Veterans Administration, will not require submittal to, and approval for publication by, the medical director.

(D) The identity of the beneficiary will not be disclosed in any medical or dental paper; and when photographs of the faces of any beneficiaries are to accompany the article, the written consent of the patient or, if he is mentally incompetent, of his guardian or nearest relative must be secured, and central office advised accordingly in submitting the paper for proposed publication.

(E) The publication of papers in any journal other than the Medical Bulletin of the Veterans Administration, by the subprofessional personnel named in (A) will be subject to the conditions specified in (C) and (D).

(F) Professional papers based on data developed during a medical research project will not be prepared for proposed publication until prior approval for such preparation has been given by the medical director. The medical director will not approve such requests for preparation of papers based on research projects unless he is fully assured that there will be no delay nor interference with the completion of the research project. (September 13, 1944.)



[6726: CLEARANCE OF MEDICAL ADDRESSES AND PROFESSIONAL PAPERS.-- (A) The Office of War Information expects each Federal agency to review and clear, in advance of delivery or publication, all speeches and articles by its officials, when not covered by Office of War Information clearance. This requirement entails checking with another agency if its policies are involved in the speech or article, and with the War and Navy Departments if there is any question of military security, and determination that the speech or article is in accord with Federal policy. The purpose of clearance is to avoid the public confusion resulting from conflicting, premature, or inaccurate statements.

(B) Papers or summaries of discussions to be read at medical meetings, when submitted to the medical director for prior approval, as provided in R. & P. 6725 (A), will be cleared in accordance with this directive of the Office of War Information before their return to the forwarding station.] (September 13, 1944.)

[6727 canceled September 13, 1944.]

#### FURNISHING NAMES OF BENEFICIARIES TO ORGANIZATIONS, ETC.

[6728. REQUESTS FOR STATES OF RESIDENCE OF HOSPITAL PATIENTS TO ARRANGE DISTRIBUTION OF CHRISTMAS GIFTS.--For the general policy governing release of addresses of beneficiaries of the Veterans Administration, see R. & P. 311 (C).] (A) To meet the situation created by requests of State organizations of ex-members of the armed forces, women's auxiliaries and other welfare groups to be supplied names of residents of their States who are hospitalized in Veterans Administration facilities in their own State or other States throughout the country, in order that Christmas gifts may be sent them, the following procedure will be observed:

(B) Annually, as of December 1, the manager of each facility under direct and exclusive jurisdiction of the Veterans Administration will circularize all mentally competent patients in his facility on that date, who, it is anticipated, will remain hospitalized during the Christmas holidays. These patients will be requested to indicate by their signatures that they authorize the Veterans Administration to furnish their names to organizations proposing to distribute Christmas gifts.

(C) Mentally incompetent patients will not be circularized, nor will effort be made to correspond with their guardians, nearest relatives or responsible representatives to ascertain if such responsible agents will permit the furnishing of names of such patients. Instead, the manager will list the numerical totals of such patients, by States, from which they were admitted, without adding their names.

(D) After this circularization of mentally competent, and numerical totalization of mentally incompetent patients is completed, the manager will have lists compiled, by States from which they were admitted, of the names of the consenting mentally competent patients; and numbers, by States, of the mentally incompetent. Such separate State lists will be supplied upon request of any recognized State organization.

(E) Managers of regional offices and facilities with regional office activities will follow the procedure outlined in (B), (C) and (D) with regard to beneficiaries of the Veterans Administration who, it is believed, will be receiving authorized treatment in other Federal (Army, Navy, Public Health Service) or State or private contract hospitals in their territories, during the Christmas holidays. Cooperation of commanding officers and superintendents of such hospitals will be secured. (September 13, 1944.)



**[6729.] REQUESTS FOR ADDRESSES OF DEPENDENTS OF HOSPITALIZED PATIENTS.**—(A) When the manager of a facility under direct and exclusive jurisdiction of the Veterans Administration is requested by a recognized organization to furnish the names and home addresses of dependents of beneficiaries who are hospitalized in the facility so contacted, he will circularize mentally competent patients as provided in R. & P. **[6728,]** and will furnish the names of such dependents to the said organization upon the consent of the patients.

(B) Managers of regional offices or facilities with regional office activities will proceed in like manner as regards requests of this kind related to beneficiaries receiving authorized treatment in other Federal, State or private hospitals. The cooperation of commanding officers or superintendents will be enlisted to this end.

(C) Where mentally incompetent beneficiaries are concerned, the consent of the guardians or nearest relatives will be obtained to release the names and addresses of the dependents. The circumstances will be clearly explained. (September 13, 1944.)

[6730 canceled September 9, 1944.]

## ASSAULTS UPON, INJURIES TO AND ELOPEMENTS OF BENEFICIARIES

6733. [INCIDENTS TO BE REPORTED; RESPONSIBILITY FOR REPORTS.—(A) (1) Prompt report on Form 2633, in duplicate, will be made of any assault upon a claimant or beneficiary, by personnel or fellow-claimants or beneficiaries; of accidental or self-inflicted injury of a claimant or beneficiary during examination, treatment, exercise or recreation; of errors in the administration of any form of therapy; of suicide or attempted suicide of a claimant or beneficiary; and of the elopement of a hospitalized psychotic patient.

(2) Any such incident occurring in a field station - facility or regional office - under direct and exclusive jurisdiction of the Veterans Administration will be recorded at that station. If the incident affected a beneficiary receiving authorized medical service at a field station of any other Government agency (e.g., Army, Navy, Public Health Service) or in a contract hospital, the report will be made at the regional office or facility having regional office activities that has territorial jurisdiction, upon receipt of notice of the occurrence. Commanding officers of other Federal hospitals and superintendents of contract hospitals will be informed of the necessity for and incidents comprehended by such notification, and will be supplied copies of Form 2633 for making such reports. Such heads of other hospitals will be instructed to execute Form 2633, in duplicate, through item 3 (with such modifications of titles as necessary) and forward it to the manager of the Veterans Administration concerned. Investigation of incidents occurring in such other hospitals will not be initiated unless requested from central office.

(B) (1) Beneficiaries who had received an irregular discharge, or been granted permitted leave of absence from a facility under the direct and exclusive jurisdiction of the Veterans Administration, or from another Government or contract hospital, will be the subject of such report if an assault be made upon them, or an accident befall them, or they commit or attempt to commit suicide, within one month after leaving such hospitalization.

(2) These specified incidents, if happening to a beneficiary who had left a facility under direct and exclusive jurisdiction of the Veterans Administration will be recorded at that facility. If happening to a beneficiary who had left a hospital at which he had been receiving treatment authorized by the Veterans Administration, record will be made by the regional office or facility having regional office activities having territorial jurisdiction.

(3) It is not contemplated that a routine follow-up be made of every such beneficiary, to ascertain whether the specified incidents had happened. The report will be made when information of any such incident is received at the field station of jurisdiction, and the managers will exchange any such information reaching them. If the information is conveyed in a newspaper, the clipping therefrom, fully identified and dated, will be made a part of the record. Investigation of these incidents will not be initiated unless requested from central office.] (September 9, 1944.)

6734. [DISPOSITION OF REPORTS OF ASSAULTS, INJURIES AND ELOPEMENTS.—Reports of incidents specified in R. & P. 6733 will be disposed of at the field station of jurisdiction, or will be referred to central office, dependent upon the character of the incidents, as follows:



(A) Elopements from open wards in facilities or separate units for care and treatment of neuropsychiatric patients will not be reported to central office, except when negligence or collusion of an employee is suspected or established. Nor will injuries to a patient, when of a minor inconsequential character, not requiring surgical attention of any kind, be reported to central office, except when such injury was the result of the negligence of, or assault by, an employee, whether suspected or established.

(B) A formal report (original Form 2633) to the medical director, or to the director of national homes, in case a member is involved, will be made in these instances:

(1) Any elopement from an open ward when negligence or collusion of an employee is established or suspected.

(2) Any elopement from a closed ward or elopements of a closed-ward patient while engaged in occupational therapy or recreational activities.

(3) Any injury, minor or otherwise, established or suspected to be due to negligence of or assault by an employee.

(4) Any injury which requires surgical attention of any kind, or which might leave residuals.

(5) Any injury, apparently minor at time of receipt, which becomes aggravated or develops sequelae proximate to the original injury.

(6) Any fracture or dislocation.

(7) Any suicide or homicide or attempt at either.

(8) Any error in medical treatment (including administration of wrong medicine, etc.).

(9) Any death during surgical operation, or shortly thereafter.]

(September 9, 1944.)

6735. [ACTION AT FIELD STATIONS.—(A) Form 2633, report of assault upon, injury to or elopement of a beneficiary, will be executed, without delay and not more than 12 hours after any incident specified in R. & P. 6733 (A) (1), by the employee immediately in charge of the ward, clinic, occupational therapy activity, out-patient unit, barracks, etc., where the incident occurred. The nature of the incident, the hour it happened or the hour it was discovered after it happened, and the names of witnesses will be carefully recorded by such employee, who will then deliver the form to his or her superior (ward physician, officer of the day, domiciliary officer) for further notations, and for reference of the form to the chief medical officer or clinical director who, in turn, will forward it, with recommendation to the manager.

(B) If the manager decides that the incident was of the minor character defined in R. & P. 6734 (A), to which had attached no collusion or negligence of or assault by an employee, he may endorse Form 2633: "No further action; file", send the form for filing with the correspondence file or medical file (out-patient) of the patient or member concerned, and destroy the copy.

(C) If the incident, while minor, was attended with suspected or established collusion or negligence of or assault by an employee; or if the incident was of a major character as defined in R. & P. 6734 (B), the manager will appoint a board of station employees to investigate it. The board will consist of a physician as chairman, and two other members, one an attorney if available, the other a physician. The chairman will be supplied the Form 2633, and will hold a hearing, calling all material witnesses, for investigation, upon conclusion of which the report and recommendation of the board will be submitted to the manager with Form 2633.

(D)--The manager, upon consideration of the board's report and recommendation, will complete Form 2633 by adding his recommendation, and will forward the original thereof to the medical director or director of national homes, accompanied by the board's report.] (September 9, 1944.)

[6736. ACTION IN CENTRAL OFFICE.--The medical director or director of national homes may (A) approve a recommendation of a manager not requiring written admonishment, reprimand or charges, and so inform him; (B) submit the report to the Administrator, through channels, with recommendation for action; (C) request, in coordination with the chief, investigation division, the manager to clarify or further develop the report.] (September 9, 1944.)

6737. [ABUSE OF BENEFICIARIES BY EMPLOYEES.--Any maltreatment of beneficiaries by employees will not be tolerated. When it is evident that an employee has subjected a beneficiary to rough-handling, appropriate action under R. & P. 6734 will be promptly taken; and reporting of the case to the United States attorney for the district, for prosecution of the offender, will be an appropriate step in any case of aggravated assault. Notices will be posted in proper places, including attendants' quarters, at field stations, warning that abuse of beneficiaries will be followed by legal prosecution.] (September 9, 1944.)



## INTERCURRENT DISEASE OR INJURY; ADJUNCT AND AUXILIARY TREATMENT

[6738 canceled September 12, 1944.]

[6740.] DEFINITION OF INTERCURRENT DISEASE OR INJURY.--(A) An intercurrent disease or injury is one which occurs in the course of another basic disease or injury. The disability from the associated basic condition may or may not be service connected.

(B) If the disability from the basic disease or injury be service connected, the intercurrent condition may be held as proximately its result, and the added disability from the intercurrent disorders may then be determined as "Proximately service connected". This determination is adjudicative, not medical.

(C) If the disability from the basic disease or injury be service connected, the intercurrent condition may be held as definitely not its proximate result and; accordingly, the disability from it is determined as not service connected. This again is an adjudicative determination, not medical.

(D) If the disability from the basic disease or injury be not service connected, then the disability from an intercurrent condition is obviously not service connected and requires no adjudicative determination. (September 12, 1944.)

[6741.] TREATMENT FOR INTERCURRENT DISEASE OR INJURY.--(A) While determination of service connection is an adjudicative and not a medical function, decision as to the necessity of treating an intercurrent disorder is a medical responsibility.

(B) An intercurrent disease or injury that has been adjudicated as proximately service connected, will be equally entitled to all treatment that is authorized for a service-connected condition.

(C) Adjunct treatment is the term to be applied to the treatment of an intercurrent disorder which, not service connected, is medically determined to be aggravating the disability from a basic service-connected condition.

(D) Auxiliary treatment is the term to be applied to the treatment of an intercurrent disorder which, not service connected, is medically determined to be aggravating the disability from a basic nonservice-connected condition.

(E) Adjunct treatment may be rendered during hospital treatment or to out-patients. Auxiliary treatment, since the basic disease or injury is not service connected and therefore not entitled to out-patient treatment, can be rendered only during hospitalization.

(F) In general, neither adjunct nor auxiliary treatment will be rendered unless the basic disease or injury is itself under treatment. (September 12, 1944.)

[6742. AUTHORIZATION OF TREATMENT FOR ASSOCIATED CONDITIONS.--(A) Chiefs of services, chief dental officers, ward physicians, and physicians occupied in out-patient activities, have authority to determine the need for associated treatment and to render it. However, such treatment will be prescribed in accordance with the governing principles hereinafter outlined, and clinical directors, chief medical officers, and chief dental officers will be required to give sufficient supervision to such treatment as will insure its proper and duly economical administration.

(B) For provision of hospitalization for adjunct or auxiliary treatment, see R. & P. 6053 and 6231. For procedure in authorizing adjunct or auxiliary dental relief in facilities, see R. & P. 6222; for procedure in its authorization on an out-patient basis see R. & P. 6556, 6557, 6561.

(C) The mere fact that a patient has a basic service-connected disease or injury, or is receiving hospital treatment for a nonservice-connected disorder, does not per se entitle to treatment of a condition associated therewith. Particularly with regard to dental adjunct or auxiliary relief, it is to be understood that purely cosmetic measures are not the consideration. The consideration is whether sound accepted medical practice would demand the treatment; and it must be restricted to such measures as may reasonably promise cure or improvement of the basic disease or injury. Should there be any doubt as to the propriety of rendering associated treatment the facts may be presented to the medical director for opinion.

(D) Exception to the foregoing may be made in cases of patients in hospitals who are suffering from chronic disabilities, such as arthritis, heart conditions, etc., who require constant medical attention and where it is reasonable to suppose they will continue to be patients of the facility for protracted periods of hospitalization. These patients may be furnished such dental relief as may be reasonably necessary to keep their mouths in a clean and healthy condition with sufficient dentition to maintain health.

(E) Associated dental treatment may be furnished patients under treatment for malignancies. Artificial replacements of lost natural teeth will not be made except upon the approval of the clinical director or chief of the tumor service.] (September 12, 1944.)

[6743 canceled September 12, 1944.]

#### DENTAL RELIEF FOR INTERCURRENT DISEASE OR INJURY

[6744.] PRINCIPLES IN PROVIDING ADJUNCT OR AUXILIARY DENTAL RELIEF.--In prescribing adjunct or auxiliary dental relief, the following principles will guide: The relief may be rendered for those inflammatory or infective processes in general which, in sound medical judgment, can reasonably be held to be aggravating a basic disease or injury that is itself under treatment. The relief must be such as, in the consensus of medical opinion, would be rounded treatment for, and can reasonably be expected to result in amelioration or cure of, the associated basic disease or injury. The extirpation of such inflammatory or infective foci will not, except where specified hereinafter, comprehend prophylaxis, fillings, crowns, etc., but may demand dental extractions. When, following extractions, the patient's dentition is sufficiently depleted, artificial dentures may be constructed and fitted (see R. & P. [6745]).

##### (A) RESPIRATORY SYSTEM DISORDERS:

(1) Abscess, lung - when due to a foreign body, no oral or dental foci of infection can ordinarily be incriminated. When due to other causes, the indications for removal of inflammatory or infective foci will be individually considered from the history and report of dental examination.

(2) Asthma, bronchial - if reasonably suspected, oral or dental foci of infection may be removed, but due recognition will be taken of current concepts as to the identity and etiology of the disease, especially as related to allergic reaction.

(3) Bronchitis, chronic - such foci as can reasonably be suspected may be eliminated.



(4) Bronchiectasis - as for bronchitis.

(5) Emphysema.- no dental relief indicated.

(6) Pleurisy - as for the relief provided for the primary condition (tuberculosis, pneumonia, nephritis, leukemia, etc.,) to which the pleurisy is secondary. Pleurisy secondary to trauma (fracture of ribs, etc.,) indicates no dental relief.

(7) Pneumonia - the characteristic process, lobar or lobular, being once established, and the organism (pneumococcus, streptococcus, staphylococcus, etc.,) recognized, progress of the process cannot be reasonably expected to be influenced materially by oral or dental relief which, besides, would interfere with the general treatment and be contraindicated by the patient's general condition.

(8) Tuberculosis, pulmonary, active - removal of oral or dental foci of infection; prophylaxis, fillings, crowns, etc., and artificial dentures, full or partial, to be supplied as necessary. The indications are to provide sufficient masticatory surface to maintain subsequent nutrition.

(9) Tuberculosis, pulmonary, Class IV, (formerly termed "quiescent") - as for tuberculosis, active.

(10) Tuberculosis, pulmonary, arrested - no dental relief indicated.

#### (B) MEDICAL AND SURGICAL DISORDERS:

(1) Adhesions, peritoneal - cases to be considered individually, with regard to actual symptoms presented (i.e., disturbances of motility, partial obstruction, reflex disturbances, pain). Dental relief will ordinarily be ineffectual and not indicated.

(2) Anemias - such inflammatory or infective foci as may reasonably be suspected as contributory to the blood dyscrasia may be eliminated.

(3) Arteriosclerosis - no dental relief would be effective in later stages of plaque formation and extensive intimal infiltration. Elimination of inflammatory or infective foci may be indicated in earlier stages. See hypertension.

(4) Arthritis, all forms with active symptoms - removal of suspected oral or dental foci of infection - in the interest of the patient's after-comfort, sensible conservatism should be exercised, but those teeth that are obviously infected should be extracted, especially where there is definite evidence of periapical involvement or of pus pockets in the gums.

(5) Cholecystitis - removal of suspected oral or dental foci of infection.

(6) Colitis - removal of oral or dental foci; any necessary prophylaxis, fillings, crowns, or artificial dentures to be supplied, as necessary.

(7) Cystitis, urinary - no dental relief (usually an ascending infection).

(8) [Dengue fever - no dental relief indicated.]

(9) Diabetes mellitus - as for tuberculosis, active.

(10) Endarteritis obliterans - removal of infective foci.

(11) Gastritis - as for colitis.

(12) Gastro-enterostomy - cases to be individually considered, in the light of the dental examination and active post-operative symptoms.

(13) Hypertension - removal of suspected foci.

(14) [Malaria - no dental relief indicated.]

(15) Myalgia, myositis - no dental relief indicated.

(16) Iritis, and other inflammatory or infective eye affections - removal of reasonably suspected dental or oral foci.

(17) Myocarditis - to be considered individually from the history and report of dental examination.

- (18) Nephritis, all forms - removal of any foci suspected.
- (19) Nephrosis - no dental relief indicated.
- (20) Osteomyelitis, active - removal of suspected foci.
- (21) Osteomyelitis, residuals - no dental relief indicated.
- (22) Otitis media; other inflammatory or infective ear conditions - removal of suspected dental or oral foci.
- (23) Phlebitis - as for osteomyelitis, active.
- (24) Pyelitis - as for nephritis.
- (25) Raynaud's disease - no dental relief indicated.
- (26) Sinusitis - removal of suspected foci.
- (27) Syphilis - oral prophylaxis during active hospital treatment.
- (28) Tachycardia, paroxysmal - removal of reasonably suspected foci.
- (29) Tuberculosis, non-pulmonary, active - as for active pulmonary tuberculosis.
- (30) Ulcers, gastric or duodenal, symptomatic - removal of infected foci; prophylaxis, fillings, crowns, etc., and artificial dentures as required.
- (31) Ulcers, gastric or duodenal, healed (non-symptomatic) - no dental relief indicated.
- (32) Valvular heart disease - removal of infective foci.

**(C) NERVOUS SYSTEM DISORDERS:**

- (1) Sydenham's chorea - removal of infective foci. Huntington's chorea; dental relief would be ineffectual and is not indicated.
- (2) Encephalitis lethargica - maintenance of teeth and gums in clean condition, with sufficient masticatory surface.
- (3) Epilepsy - sufficient dental relief to insure due mastication.
- (4) Hyperthyroidism - removal of foci.
- (5) Hypothyroidism - investigate and remove suspected dental or oral foci, if glandular therapy is not sufficient.
- (6) Multiple sclerosis - removal of suspected foci.
- (7) Neuritis - removal of infective foci.
- (8) Neurocirculatory asthenia - removal of reasonably suspected foci.
- (9) Psychoneuroses - because of the psychogenic basis of these disorders, no dental relief is indicated.
- (10) Psychoses - no adjunct relief for out-patients. For hospitalized beneficiaries, see R. & P. 6223.
- (11) Traumatic brain or cord lesions - no dental relief indicated.

(D) Periodontoclasia (pyorrhea alveolaris) sufficiently progressed to show characteristic evidences (pus), and permit clear differentiation from gingivitis, salivary deposits, gum recession and other normal devolutional changes, will be regarded as focal infection requiring treatment adjunct or auxiliary to the diseases named in (A) to (C) hereof. Acute oral conditions (e.g., Vincent's stomatitis, acute dento-alveolar abscess), except when evidently acute exacerbations of a chronic infection, will be regarded as not requiring relief as adjunct or auxiliary to basic diseases. (September 12, 1944.)

6745. DENTAL PROSTHESIS IN ADJUNCT OR AUXILIARY RELIEF.—When in rendering adjunct or auxiliary dental relief it becomes necessary to extract such number of teeth for a patient [which, together with teeth previously lost,] would result in the serious depletion of his masticatory efficiency, such missing teeth may be replaced



with artificial substitutes. A satisfactory method of determining deficiency of masticatory apparatus for replacement purposes is to determine whether replacement logically requires the use of full or partial removable dentures. If a sufficient number of teeth have not been lost as to require the use of removable dentures it should ordinarily be held that replacements are not indicated. This criterion may be modified to a reasonable extent in such conditions as tuberculosis and digestive disturbances, where a quite efficient masticatory apparatus is required; as well as in psychotic patients whose mental condition may require fixed replacements; provided that such beneficiaries are otherwise entitled to such service. (September 12, 1944.)

**6746. REPLACEMENT OF DENTAL PROSTHESIS SUPPLIED IN ADJUNCT OR AUXILIARY RELIEF.--** When teeth have been extracted to remove foci of infection and have been once replaced by artificial substitutes, there is no obligation to keep such dental prosthetic appliances in repair, or to replace them when they become unserviceable for any reason or are lost or destroyed, unless the basic disease or injury requires that replacement be made as intercurrent relief, as in the treatment of tuberculosis and digestive disturbances. In such conditions as arthritis, heart lesions, kidney lesions, etc., where foci of infection have been removed and replacements made, subsequent repairs or replacements of such dental prosthesis will not be made. (See also R. & P. R-6135 (C) and R. & P. [6223 and 6742]). (September 12, 1944.)

**[6747.] ADJUNCT OR AUXILIARY DENTAL RELIEF IN ARMY, NAVY, OR MARINE HOSPITALS.--** When a beneficiary is receiving authorized treatment in a United States Army, Navy or Marine Hospital, adjunct and auxiliary dental relief will be authorized by the authorities of the hospital concerned in the manner usually employed in such authorizations for their own beneficiaries, and must be completed, if at all feasible in the dental clinic of such hospital, during the period of hospitalization necessary for the basic disease or injury. Regional offices and facilities with regional office activities will under no circumstances authorize adjunct or auxiliary dental relief to be rendered in any such Government hospital, except out-patient adjunct treatment at the Naval Hospital, Philadelphia. (September 12, 1944.)

**[6748.] WHERE ADJUNCT DENTAL RELIEF IS NOT COMPLETED IN OTHER FEDERAL HOSPITALS.--(A)** For patients discharged from Army, Navy or Marine Hospitals with uncompleted dental relief authorized as treatment, adjunct to a service-connected disability, the question of the necessity of furnishing further out-patient adjunct dental relief may then be given consideration by a regional office or facility with regional office activities concerned. Such cases will be handled without regard to what may or may not have been authorized in such hospitals, the consideration being based entirely on the necessity of treatment, as hereinbefore provided. Exception may be made in cases where such numbers of teeth had been extracted in the hospital as adjunct relief that the masticatory surfaces had been seriously depleted. Where such serious depletion had resulted from extractions as auxiliary treatment for a basic nonservice-connected disease or injury, the provisions of R. & P. [6231] will be observed. (September 12, 1944.)

**[6749.] DENTAL RELIEF IN NAVY HOSPITALS.--**Except as to the Naval Hospital, Philadelphia, the hospitals of the Navy Department will not, under Navy Regulations, construct dental prostheses for patients of the Veterans Administration receiving authorized treatment therein. Chief medical officers and their designates in regional offices and facilities with regional office activities will be accordingly advised and guided. (September 12, 1944.)

6750. DENTAL RELIEF IN CIVIL CONTRACT HOSPITALS.—Where a beneficiary is in a civil contract hospital, and it is the opinion of the superintendent thereof that adjunct or auxiliary dental relief is required, he will so inform the regional office or facility with regional office activities concerned, adding an explanation as to the necessity. The chief medical officer, if he considers that the need of adjunct or auxiliary dental relief is sufficiently shown, may authorize relief required through the facilities of the contract hospital, if available; or may arrange for transfer of the patient from the contract hospital into a Veterans Administration facility, provided further hospitalization is necessary at all; or through the chief dental officer, he may authorize rendition of adjunct dental relief only through a station of the Veterans Administration or through a designated dentist. [(See R. & P. 6556, 6558 and 6559).] (September 12, 1944.)

[6751 - 6758 canceled September 12, 1944.]

### DENTAL CLINICS IN FACILITIES AND REGIONAL OFFICES

6760. SUBPROFESSIONAL PERSONNEL NOT TO PERFORM DENTAL OPERATIONS.—Dental assistants or dental laboratory mechanics will not be permitted to perform dental operations for beneficiaries of the Veterans Administration. [Dental] hygienists will not perform any operations except prophylaxis and treatment of the gums. Any violation of this instruction will be grounds for preferment of charges. (September 12, 1944.)

[6761.] MAKING OF DENTAL EXAMINATIONS.—Since dental examinations are the basis for authorization of dental relief, they will be made, whenever possible, by the chief dental officer. In no event will they be made and recorded by other than a dentist. (September 12, 1944.)

[6762.] RECORDING DENTAL EXAMINATIONS.—(A) In-patient and domiciliary dental examinations will be recorded on Form 2614p, and out-patients on Form 2570. It is imperative that dental examinations be accurate and comprehensive, so that they portray in detail the conditions, both normal and pathological, which obtain in the patient's mouth. [ ] Not only must fillings, if any are present, be noted, but their location in the tooth must be indicated. Prosthesis replacing missing teeth must be shown [indicating] whether serviceable or not, and if the latter, in what respect they are unserviceable. If replacements are indicated for teeth previously extracted, information must be furnished as to whether the beneficiary had heretofore worn dentures; and if so, when and by whom they had been constructed and why they are not now being worn. Any unusual or pathological condition of either hard or soft tissue, or the articulation should be recorded. In brief, a report of dental examination should convey an accurate picture of each tooth individually, as well as of the oral cavity as a whole.

(B) Final diagnosis will not be made until such radiographs as were necessarily taken in the case are read, so that the findings may be incorporated in the report of dental examinations.

(C) If partial dentures are being prescribed as part of the treatment indicated, the numbers of the teeth to be used as clasp or other anchorages will be specified.

(D) In case of gunshot wounds of the face or jaws, residuals of osteomyelitis, etc., an accurate description will be given of any abnormal conditions, including



their location and extent, the examiner's complete findings, and the medical diagnoses in the case, so that a rating board may accurately visualize and evaluate the entire disability. (September 12, 1944.)

**[6763.] EMERGENCY DENTAL TREATMENT FOR EMPLOYEES OF THE VETERANS ADMINISTRATION.--**(A) The dental treatment rendered employees must be of emergency nature only, consisting of such extractions, treatment of abscess, etc., as will relieve pain and discomfort and enable the employee to resume his work. Repair or replacement of broken or ill-fitting dentures or bridges or other dental prosthesis will not be considered; and dental radiographs will be taken only when actually necessary as a diagnostic measure to determine the type of emergency treatment to be rendered.

(B) Requests for emergency dental treatment of an employee will be made on Form 2534 [by the division chief and will be routed in accordance with the instructions printed on the form. See also R. & P. R-6127 (C).] (September 12, 1944.)

**[6764.] EMERGENCY EXTRACTION OF BENEFICIARIES' TEETH.--**(A) When extractions are indicated as an emergency measure, the beneficiary, before extraction is undertaken, will be required to sign the following statement: "I understand and agree that the extraction of tooth No.(or teeth Nos.)--, is being performed for my benefit and relief, and such extraction does not entitle me to artificial replacement for the lost tooth (or teeth)."

(B) This certificate will be typed on the report of dental examination or, if no space is thereon available, on a separate small sheet of paper, and securely stapled to the report of dental examination. Should the beneficiary decline to sign this release, the extraction will not be performed.

(C) The provisions of (A) and (B) hereof are not applicable to hospitalized patients who are mentally incompetent. (September 12, 1944.)

**6765. [CONSTRUCTION OF SPECIAL APPLIANCES.--**When it becomes necessary to fabricate special prosthetic appliances in the treatment of a beneficiary, requiring the services of a commercial dental laboratory, or the procurement of special equipment or supplies (exclusive of porcelain facings with backings, or porcelain pontics or tube teeth) the prior authority of the medical director will be secured. In requesting such authority the name and claim or register number of the patient will be given, the authority under which treatment is to be furnished, a description of the appliance and necessity therefor, and estimate of the cost of services or materials will be submitted. Excepted from this provision are various types of splints required in reducing fractures of the bones of the face and jaws.](September 12, 1944.)

**[6766 canceled September 12, 1944.]**

### DENTAL CLINIC RECORDS

**6767. RADIOGRAPHS.--**(A) [Dental radiographs including occlusal and bite-wing films will be secured when indicated in making a diagnosis of dental and oral conditions. They may also be taken postoperatively to check the results of extractions, or to record progress of treatment. They will be taken following reduction of fractures and dislocations and to check the results of root-canal therapy and filling.

(B) The dental X-ray unit will be located in the dental clinic and the exposures made by a dentist, unless other arrangements are authorized by the medical director. Exposed films will be referred to the X-ray laboratory for developing and drying by the X-ray technician.

(C) The films will be promptly returned to the dental clinic where they will be mounted in appropriate sized mounts (F.S.S.C. Items 18-M-2200 - 2225, inclusive). The mount will be plainly marked with the patient's name, claim or register number, X-ray serial number, date, station, and numbers of the individual teeth shown. The chief dental officer will keep records of films on hand, used, etc., as may be required by instructions currently in effect.

(D) Mounted dental radiographs will be inclosed in standard dental radiograph envelopes (F.S.S.C. Item No. 53-E-4751), and filed in accordance with existing instructions.] (September 12, 1944.)

6768. DENTAL APPOINTMENT BOOK.--A Dental Appointment and Record Book, Form 2679, will be kept by each dental officer engaged in any clinical activities, and by each [dental] hygienist. This book is intended not only as a record of services rendered, but also for noting appointments for subsequent sittings. The name, claim [number or] register number and designation, (out-patient, [in-patient or] domiciliary) of every person given an appointment or for whom an examination was made, or treatment, however minor, was rendered, will be entered in this book. If an appointment was broken that fact will be noted. The description of treatment rendered will be noted as well as the time consumed in rendering it, and in making examinations, [recorded as of the nearest quarter-hour]. From the information contained in the appointment book, the daily record of dental service rendered will be entered on Forms 2570 and 2614p. The Monthly Report of Dental [Operators, Form 2587 revised, will also be compiled from the information contained in this book. Detailed instructions for maintaining this book as printed on the inside of cover will be observed.] (September 12, 1944.)

6769. [MONTHLY REPORTS.]--(A) Monthly Report of Dental [Operators,] Form 2587 revised, will be submitted by each dental officer engaged in clinical activities and by each [dental] hygienist. If the employee is transferred during a calendar month, a report will be submitted from each station at which the employee was on duty. If no dental operations were performed, [ a ] Form 2587 will be submitted showing "Nothing to report".

(B) [In addition to the foregoing, chief dental officers will submit Monthly Report of Dental Clinics, Form 2587a revised, showing the status of the activities of the clinic as a whole.

(C) Both Forms 2587 and 2587a will be compiled in accordance with the detailed instructions printed on the back of the form, and such other instructions as may be issued from time to time.

(D) The reports will be prepared in triplicate in sufficient time to permit of the dispatch of the originals to central office, marked for the attention of the budget officer and chief of statistics, not later than the tenth of the following month. One copy will be filed in the office of the chief dental officer and the other in the clinical records office, or such other place as may be designated by the manager.] (September 12, 1944.)

[6770.] USE OF FORM 2504.--Form 2504, Decision of Questions of Fact and Law, will be executed in all cases involving the expenditure of funds for professional services, or the purchase of dental supplies for individual beneficiaries. (September 12, 1944.)

6771. [ISSUES OF DENTAL GOLD TO A CLINIC.--Dental gold will be issued to the dental clinic in accordance with Regulations and Procedure, Supply, in the original



units of issue prescribed by the Federal Standard Stock Catalog. Except in the case of lingual bars, the chief dental officer will take up gold issued to him by troy weight, and will issue it for use in the construction of dental appliances by weight. Care will be exercised to prevent the accumulation of gold which will be surplus to the reasonable requirements of the station.] (September 12, 1944.)

**[6772.] CUSTODY AND RESPONSIBILITY FOR GOLD IN DENTAL CLINICS.**---(A) The chief dental officer will have custody of all dental gold in the clinic, and will be held responsible for its safekeeping. He may, if he desires, delegate the duty of issuing gold to one of his subordinates, but such delegation of duty will not relieve him from his responsibility. During the absence of the chief dental officer, the acting chief dental officer will take custody of and assume responsibility for the dental gold.

(B) After the official designated under the provisions of R. & P. 6774 has weighed and checked the gold, he will be held responsible for the amount of gold on hand according to his certificate, and for the period for which he checked the gold. (September 12, 1944.)

**6773. ISSUE OF GOLD IN A DENTAL CLINIC.**---(A) When gold is required for the construction of a piece of dental prosthesis, the dentist or dental mechanic will estimate the amount of each different kind of gold required on a Gold Issue Slip, Form 2609, in duplicate, and present it to the employee handling the gold. The amount of each kind of gold (except lingual bars) issued, will be weighed, and the weight noted in the appropriate space on the Forms 2609, the original of which will be retained and the duplicate given the employee requisitioning the gold.

(B) Upon completion of the work, unused gold, [including clippings, will be returned, weighed, and the weight entered on Form 2609. The expense of reclaiming filings and grindings is not justified by the value of the gold salvaged. Accordingly they will not be saved. The difference between the "Amount issued"] and the "Amount returned" will be entered as the "amount actually used", to be dropped as an authorized expenditure. Both copies of the gold issue slip will be fully executed. The original slips will be filed in the clinic for at least one year, following which they may be reported as inactive records as provided in R. & P. 630-636, inclusive. The duplicate slip will be returned to the employee who used the gold, as his personal record.

(C) Form 2598f, Property Record Card (Expendable), may be used as a convenient record of receipts, expenditures and balances of dental gold in the clinic. (September 12, 1944.)

**[6774.] CHECKING CLINIC GOLD RECORDS.**---The manager will designate a responsible official to verify the record of receipts, issues and balances of gold in the dental clinic, and to check the records against the amount of gold actually on hand, ascertained by weighing. This check will be made quarterly on January 2, April 1, July 1, and October 1, or the next working day thereafter. All variations will be made a matter of record. If, however, the variation is to an extent no greater than five percent and it is found that such variation is due only to inaccuracies in weighing and loss in melting, polishing, et cetera, and not to careless handling, improper use or misappropriation, an adjustment to cover the variation may be permitted. After weighing and checking the gold, the designated official will furnish both the manager and chief dental officer with a signed statement reading:

"I certify that I have this date weighed the gold on hand for issue in the dental clinic, checked the amounts against the record of receipts, expenditures and balances and find same correct (and find the following discrepancies:-)". If any inaccuracies are reported by the official making the check which do not come within the excusable limitation, the manager will submit a detailed report to the medical director, requesting instructions in the premises. (September 12, 1944.)

[6775. At the end of each quarter, or more frequently, if indicated, all the several types of gold on hand will be surveyed and all clippings and small pieces not usable for the purpose intended, as well as nuggets of casting gold which have become unserviceable due to overheating or repeated melting will be set aside and weighed. A Form 2609 will be prepared, inserting the word "scrap" in the space provided for the patient's name, and the weights of the various types of gold in the appropriate spaces. All this scrap gold will be melted into one ingot and taken up on the gold ledger, as required by R. & P. 6779, to be subsequently turned over to the supply officer.] (September 12, 1944.)

[6776.] DISPOSITION OF OLD PROSTHESIS CONTAINING GOLD.--(A) When any prosthesis containing gold (bridges, bar or clasp dentures, crowns, inlays, etc.,) are removed from the mouths of patients in a clinic, the chief dental officer will ascertain whether the appliance was originally furnished by the Veterans Administration, or was procured by the patient at his own expense. This information may be secured by questioning the patient, or preferably, if practical, procured from the C-file. In all cases where the beneficiary is a patient in a neuropsychiatric facility, or if he is incompetent, this information will be obtained from the C-file, by request upon the [office] in possession thereof.

(B) If the prosthesis was furnished the patient at Government expense it will be retained by the chief dental officer, and recorded in the ledger required in R. & P. [6779,] to be disposed of in accordance with the provisions of subparagraph (E) hereof.

(C) (1) If the evidence shows clearly that the prosthesis was constructed at the expense of the patient, any natural teeth attached to it will be removed, the appliance cleaned and offered to him as his property. A record will be made in the gold ledger required by R. & P. [6779,] and if he desires to accept it, it will be given him and his receipt therefor secured, by having him sign a statement "Received the above gold-bearing appliance (date)", which will be written on the line following the description of the appliance. (2) If the patient does not desire to accept the appliance, he will be required to sign the statement "I do not desire to accept the above gold-bearing appliance (date)", written on the line following the description of the appliance. In the latter event the gold thereupon becomes the property of the Veterans Administration and will be disposed of under the provisions of subparagraph (E) below.

(D) When a gold-bearing appliance removed from the mouth of a patient in a neuropsychiatric facility, or in a locked ward at any other facility, is ascertained to belong to him, such appliance will not, however, be given the patient. After natural teeth have been removed and the appliance cleaned, the chief dental officer will execute a [ ] Patient's Effects Slip, Form 2270, in duplicate, briefly describing the appliance, and transmit it, with the original card, to the supply officer, securing his signature to the duplicate as a receipt.



(E) Old gold-bearing appliances belonging to the Veterans Administration will have all other materials removed from the gold; the latter will be weighed and entry made in the appropriate place in the gold ledger, as required by R. & P. [6779.] (September 12, 1944.)

**[6777.] GOLD-BEARING APPLIANCES REMOVED BY DESIGNATED DENTISTS.**---(A) When dental treatment is authorized to be rendered by designated dentists which involves the removal of any fillings, crowns, bridges, or dentures containing gold, the chief dental officer will ascertain from the patient's C-file whether they were constructed at the expense of the Veterans Administration. The designated dentist will be advised in each case on this subject, and given instructions as to the disposition of the old appliance.

(B) If the appliance was constructed at Government expense it will be returned with the completed oral examination blank, and disposed of as required by R. & P. [6776 and 6779.]

(C) If the C-file contains no record of the Veterans Administration constructing the appliance, the designated dentist will be instructed to remove all natural teeth, clean the appliance, give it to the patient, secure his receipt therefor and forward the receipt with the completed oral examination blank. The receipt will contain a description of the appliance.

(D) In the event the designated dentist fails or declines to return the old appliance or a receipt therefor, as may be appropriate, the estimated value of the appliance as old gold will be deducted from the voucher for the services rendered. (September 12, 1944.)

**[6778.] DISPOSITION OF NEW GOLD-BEARING APPLIANCES.**---Newly constructed gold-bearing appliances which do not and cannot be altered to fit, will be disposed of in the manner provided for Government-owned appliances in R. & P. [6776 and 6779.] After the description of the appliance in the gold ledger, will be entered the word "New". Appliances constructed for patients and which are uncalled for, will be held for a period of 90 days, after which they will be handled as non-fitting appliances. (September 12, 1944.)

**[6779.] GOLD LEDGER.**---(A) The chief dental officer will keep a ledger record of all gold-bearing appliances removed from the mouths of patients, divided into two sections:

(1) The first section will contain a record of all appliances which were constructed at the patient's expense. Each entry will consist of the date, name, and claim number or register number of the patient, and a description of the appliance. Disposition of each appliance must be shown by appropriate notation over the patient's signature on the line following the description of the appliance.

(2) The second section will contain a record of all Government-owned appliances. Each entry will consist of the date, name, and claim or register number of the patient, description of the appliance and weight. If the appliance was turned in by a designated dentist, his name will also appear. Appliances recorded in the first section of the ledger which are not desired by the patient will be again recorded in the second section.

(B) At the end of each quarter, at the time check is made of the clinic gold, the weights of the appliances will be totaled, the scrap referred to in R. & P. [6775] entered on the next following line and a grand total struck. The prosthetic appliances will be melted into an ingot separate from the scrap, and the entire quantity of gold as shown by the grand total will be turned over to the supply officer and his receipts therefor secured on the line next following the grand total. (September 12, 1944.)



## SOCIAL WORK

6781. [ORGANIZATION FUNCTIONS.--(A) The social worker in charge of the social work department at regional offices and facilities will be under the general supervision of the chief medical officer or clinical director. The department will be responsible for (1) collaboration with physicians in the social study and treatment of the personal circumstances related to veterans' health, recovery, community adjustment, and reduction of disablement; (2) cooperation with adjudication, insurance, and vocational rehabilitation authorities, and the chief attorney in securing data pertinent to the veterans' and other beneficiaries' maximum utilization of the benefits administered by those authorities; (3) completion of field examinations when the nature of the contacts, the information desired, or the interests of economy of travel make it advisable to utilize the services of a social worker. See R. & P. 5050-5060; and 5293-5296; (4) the establishment of coordinated, useful working relationships with private and public social and health agencies in advancing the hospital and community adjustment of veterans; (5) discussion of the social aspects of illness and disability with the station staff, social work students, and volunteer groups; (6) cooperation in research projects aimed at improving Veterans Administration health services to veterans.

(B) The social study and treatment undertaken, whether in the out-patient department, the hospital, or the field will be in close collaboration with the physician responsible for the examination and treatment of the veteran, to insure that it constitutes an integral part of the physician's over-all plan for that veteran. The individual social worker is responsible for the complete harmony of the social measures taken with the physician's program. This requires frequent conferences between the physician and social worker, as well as precise social work entries in the veteran's file as to the social data obtained and the action taken. The physician will constantly be in control of the social work activities relative to the patient.]

(January 22, 1945.)

6782. [OFFICE LOCATION; SPACE AND EQUIPMENT; MATERIAL ROUTINELY TO BE SUPPLIED THE DEPARTMENT; ATTENDANCE AT STAFF MEETINGS.--(A) The office location will be determined with due regard to accessibility for the chief medical officer, hospital and out-patient medical staff, patients, and their relatives; and with due regard to privacy for interviews and dictation.

(B) There will be supplied as standard equipment a lettersize 4-drawer cabinet; 3 x 5 card cabinets for permanent records of cases referred; appropriate telephone service; a copy of the general, medical, legal, and adjudication sections of Regulations and Procedure; and for each social worker, one 5 x 8 card cabinet.

(C) Stenographic and clerical service adequate to permit the maximum volume of social work accomplishment will be supplied.

(D) In facilities there will be furnished (1) copy of the daily census report; (2) copy of the Clinical Record Brief, Form 2614a, for each patient admitted; (3) copies of the clinical laboratory reports of patients and domiciliary members with positive findings of syphilis, gonorrhea, tuberculosis, and other communicable diseases. These copies will be recommended for destruction in accordance with approved procedure for disposal of inactive records, at yearly intervals, or more often, unless the copies in (2) and (3) have been made a part of the individual veteran's temporary social record.

(E) The social work department will be represented at administrative staff meetings; at diagnostic and discharge conferences regarding neuropsychiatric patients,



and when desirable, regarding other patients, to present pertinent social and emotional factors involved in the patient's illness and to participate in joint planning for the patient's welfare.】 (January 22, 1945.)-ENCLOSURE NOTED

6783. 【MAINTENANCE AND DISPOSITION OF RECORDS AND REPORTS.--(A) The following records will be maintained:

(1) A permanent 3 x 5 card for each case referred, showing the name, address, C-number, date and purpose of reference, and date of closing. Optionally, a brief abstract of the action taken may be recorded on the back of the card.

(2) Temporary 5 x 8 statistical cards by each social worker to record the social worker's case load, and data for the monthly statistical report. Informal notes, as desired, may be entered on the back of these cards. The cards on closed cases will be recommended for destruction in accordance with approved procedure for disposal of inactive records, at the end of the fiscal year, or, at the end of three fiscal years, if an individual social worker desires their retention, (as official records) for a research project. In the latter case the cards on closed cases will be removed from the active filing equipment and stored as inactive records for the remaining two years.

(3) A 3 x 5 card diary file, indexed by year and month, showing cases referred for future action that must not be overlooked, particularly in the absence of the individual social worker responsible for the case.

(4) A 3 x 5 card record of the names, addresses, and functions of social and health groups and cooperating individuals, as a supplement to formal directories.

(B) The original or official copy of social studies, of memoranda, of reports, and of incoming letters and the file copy of outgoing letters, will be filed as follows:

(1) When the veteran is not hospitalized at the station, in the case file. If there is no case file, then in the alphabetical abeyance file; otherwise, in the miscellaneous correspondence file. (See R. & P. 612.)

(2) When the veteran is hospitalized at the station, in the clinical record. Incoming correspondence containing significant social data, will be so identified and placed in the clinical record, supplementing the summary of data and action recorded on Form 2614b-1. Other correspondence will be filed in the correspondence file.

(3) Regardless of the location of the case file, the original or a copy of each full social investigation report, and other social data of significance from a medical or rating viewpoint will be sent to the station holding the case file, for filing therein. Hospitals without regional office activities will take special precaution to observe this instruction. A copy of any material of particular significance to the chief attorney regarding incompetent veterans or minor wards, will be sent to his office. (See (1) and (2).)

(4) To expedite service, the social worker may temporarily retain in an individual folder for each case one unofficial copy of reports and correspondence and two copies of the history sheet (that is, the record of interviews and social work action taken). In facilities, when the social record is closed, the original of the full history sheet will be filed in the clinical file following Form 2614b-1. In regional offices, it will be filed in the case files. In closed cases no original or official copies will ever be retained in this temporary file. These temporary files following inactivity for three years will be recommended for destruction.



(5) Ultra-confidential data, of significance only in out-patient treatment of a patient, will be placed in the case file in a sealed envelope to be opened only by the manager, a physician, or social worker; in a facility the data will be retained until the case is closed in the social work file, with a reference on the Form 2614b-1 to its existence; and then filed in the clinical record.

(C) Direct quotations to the veteran of social data, regardless of the source thereof (e.g., private agencies, American Red Cross, Veterans Administration social workers) will be scrupulously avoided because of the danger of jeopardizing the veteran's relationship to persons who have been willing to assist the Veterans Administration in furnishing information upon pledge of maintenance of confidentiality. (See R. & P. 317).] (January 22, 1945.)

6784. [TRAVEL OF SOCIAL WORKERS.--(A) Social work travel will be performed by the station nearest, that is, the most accessible, to the locality to be visited. Each station is responsible for determining with adjacent stations, its own travel area. This will generally correspond to the station's out-patient medical examination area.

(B) At stations with regional office activities, the proposed itinerary before being presented to the manager for approval, will be coordinated with the chief attorney's office to permit interchange of borderline assignments. Similar coordination will be effected before requesting another station in the same regional area to perform travel. This will prevent two representatives from traveling into the same territory when the assignments are such that one person is equipped to handle them all.

(C) Travel within a 50-mile radius from a station without regional office activities need not be coordinated with the nearest regional office when time does not permit, but such coordination is desirable.

(D) When efficiency requires that a social worker at a facility perform travel in the case of a patient under observation or treatment in an area that is nearer another station, and there is an appreciable difference in travel expense involved, the advance authority of the medical director will be secured for such travel. This procedure will also be applicable to patients on trial visit.

(E) Requests for investigations subsequently found unnecessary will be canceled immediately.

(F) Authority will be requested from central office when it is desirable for the social worker to drive the station car in field work.

(G) Every effort will be made to reduce the volume of time required for travel by the use of correspondence, telephone services and records available from other agencies, automobile transportation, services of other traveling representatives of the Veterans Administration, by interviews with relatives or friends of patients who are visiting the station and by review of medical and social data in the case file.

(H) Duplication of study and conflicting counsel will be eliminated by the advance registration of all full social study and treatment cases with the social service exchange. Authority to make the original contract for any required payment for these services will be secured of central office.] (January 22, 1945.)

6785. [ELIGIBILITY FOR SOCIAL SERVICE.--(A) Eligible for social treatment services are the following:

(1) Veterans receiving hospital or out-patient treatment, domiciliary care or vocational rehabilitation.

(2) Veterans on trial visit status, regardless of the service connection of their condition.



(3) Veterans in receipt of compensation or pension for service-connected disabilities.

(4) Deceased veteran's dependents and minor wards in receipt of monetary benefits from the Veterans Administration to the extent of rendition of emergency services until responsibility can be placed with an appropriate State or local social agency.

(B) Eligible for social study only, but not necessarily for social treatment services, unless in the above categories, are: (1) claimants and their dependents, regarding whom a social study is required to permit the establishment of the cause, history and nature of their health situation, extent of disablement, adjustment, and personal welfare; to permit determination of the appropriate form of medical treatment for a veteran; or permit a decision in relation to eligibility for benefits administered by the Veterans Administration; (2) minor wards, to determine whether their interests and welfare are protected; (3) former Veterans Administration patients regarding whom, for scientific medical purposes, a report is needed by the medical staff to determine the end-results of the medical treatment rendered.

(C) Veterans found during medical examination (regardless of the purpose) in need of out-patient treatment to which they are ineligible as beneficiaries of the Veterans Administration, will be referred to the social work department for steering to a suitable medical or social resource in the veteran's home community, for the indicated out-patient medical or social treatment, thereby precluding as far as possible the necessity for early hospitalization. (January 22, 1945.)

6786. [SOCIAL STUDY AND TREATMENT PROCEDURE IN FIELD AND OUT-PATIENT WORK.—

(A) A request from medical, adjudication, insurance, vocational rehabilitation, or board of veterans appeals source or chief attorney for social study will state the issues involved; the period or periods to be covered when the report is less than comprehensive; the disability or disabilities upon which the claim is based; special data, the obtaining of details pertaining thereto being regarded as essential; and the names of persons or institutions to be contacted.

(B) Hospital requests for social studies will be accompanied by the tentative diagnosis, date of hospital admission, names, relationships, and addresses of relatives, and any other sources of information obtainable. The verified home address and directions for reaching rural addresses are essential. Reports to hospitals will be made in duplicate.

(C) No complete social study or other service involving considerable travel expense will be undertaken without full knowledge of the present contents of the case file. To meet the issues and avoid duplication of interviews and requests of persons for written statements or other material already in file, the case file will be thoroughly reviewed in advance by the person making the study. The temporary transfer of the case file may be requested for this purpose. The file will be reviewed and returned as promptly as possible.

(D) Prior to hospitalization of a veteran for neuropsychiatric observation in a diagnostic center, the case file will be reviewed by a social worker and social data so marked that the chief, neuropsychiatric service, or other designated physician, can determine whether additional social data are essential. If essential, the data will be secured and forwarded with the file to the diagnostic center in time to be available to the examining physicians there.

(E) The social study will be directed precisely toward the issues involved. It will not seek to include all possible facts which may later be required in some



other connection. It will be borne in mind, however, that other Veterans Administration authorities may be currently, or in the near future, concerned with the veteran. Significant supplementary data not definitely sought but incidentally secured in meeting the original request will be incorporated in the report, with the interests of other departments in mind. For example, a trial visit supervision report will be primarily concerned with the nature of the veteran's personal adjustment and the case work performed to further it. The report will be written, however, with awareness that it may soon be reviewed by adjudication agencies in connection with determining the veteran's competency or need for a guardian; the chief attorney in connection with the appointment of the most appropriate guardian; insurance authorities in determining the existence of permanent total disability and the date it began; or by the vocational rehabilitation authorities in deciding whether and what type of training is advisable.

(F) Reports will be submitted in topical outline form and, in the case of the original history, preferably according to Outline for Psychiatric Social History, Form 2814. Precision, including accurate statement of dates, will be used in reporting pertinent events in the veteran's health history that portray the on-set, nature, and extent of the disability. The report will also reflect recognition of factors in the environment and inter-personal relationships that are significant from the viewpoint of treatment.

(G) Interviews will be carried out not merely to secure information, but to recognize and set in immediate motion constructive services, either by the Veterans Administration, or if beyond its jurisdiction, by others. Particular care will be taken, in the case of non-hospitalized veterans whose ineligibility for out-patient treatment precludes continued case work service, to place them in touch with appropriate community resources and, with the veteran's written consent, interpret their problems to those agencies.] (January 22, 1945.)

[6787. HOSPITAL SOCIAL WORK.—(A) The patients selected routinely for social study interviews, as the most likely to present acute social problems retarding response to medical treatment, will include the following groups in approximately the order shown, — reception service, neuropsychiatric, tuberculosis, venereal disease, cardiac, cancer, gastric ulcer, diabetes, surgical, nephritis, allergy, malaria, anemia. A physician, however, may refer to the social work department, for personal help, or for enlistment of the help of social agencies, a veteran whose advantageous use of the medical facilities available to him, completion of the treatment needed and ability to plan for the future, maintain treatment results, and keep his personal disablement to a minimum, are thwarted by such social factors as home and personal situations and responsibilities; unsatisfactory inter-personal relationships; and anxiety or other disquieting feelings.

(B) The aim will be to enable patients to remain for hospitalization; complete it in the minimum time; and leave with a clear understanding of their health problem, its restrictions upon physical exertion either during work or recreation, the medical recommendations, e.g., as to further out-patient treatment, as well as the cooperation for which they themselves are responsible in maintaining their health, knowledge of existing resources for help with their problems; definite plans as to their next steps; and justifiable confidence in the assets they possess, and in their ability to make a satisfactory personal and occupational adjustment.

(C) In social work with psychotic patients, action will be taken to relieve personal problems, attitudes, and home situations that have direct bearing on the patient's health; to arrange trial visits upon the request of the ward physician



and to make a continuous joint study of the ward population with the physician in order to recognize those patients whose homes are known to be favorable to their welfare on trial visit or discharge or for whom a reasonably satisfactory placement with persons other than relatives, can be arranged.

(D) The social worker who is to make a pre-trial study will be furnished by the hospital social worker with the dates of the patient's present hospitalization; diagnosis; description of his personality; name, address, and relationships of the persons with whom the patient expects to live; his emotional attitudes toward the members of his family and theirs toward him so far as known; any social problems he faces in his environment, personal and physical; his plans and potentialities for making a social, recreational, and occupational adjustment; suggestions regarding a suitable occupation or daily schedule for him; and any recommendations from the physician which will enable the social worker doing the field work to enlist the cooperation of the family and local organizations, in this trial visit and later, to carry out adequate supervision of the patient at home. The report returned to the hospital will cover information regarding the home conditions, the attitude of the family toward him and the proposed visit, probable income arrangements which can be made, either through the Veterans Administration or private sources, and the ability of the family and guardian properly to care for the patient in the community; also the neighborhood environment and influences, and the possibility of his securing employment, adequate recreation, and any out-patient medical treatment needed.

(E) Initiative and resourcefulness will be used in preparing home and community for intelligent, favorable reception of the patient. Adequacy of funds for the trial visit period and transition to community life will be checked and action taken to assure same through Veterans Administration or other channels. The report of the situation and steps taken to modify adverse factors will help guide the physician in determining whether a trial visit is advisable. If it is granted, the station performing the field work will be promptly supplied with the beginning date and proposed length; also suggestions as to further medical and social supervision, if necessary, and the date a report is desired. The latter station will then assume responsibility for the social measures recommended by the facility. The appropriate physician and the social worker there will take the necessary steps toward assisting the patient to achieve a satisfactory community adjustment. The work will be correlated with that of the chief attorney if the patient is under guardianship or if an institutional award has been approved.

(F) The Veterans Administration has responsibility for assistance in preventing the advance of a communicable disease, especially venereal disease and tuberculosis, not only in reference to the patient but to others with whom the patient has been or will be in contact. (See R. & P. 6714.) Veterans found upon hospital (or out-patient) examination to have a venereal disease will be referred to the social worker for the offer of assistance in arranging with civilian clinic resources for any needed future out-patient treatment for themselves or for the examination of those with whom they have been in association.

(G) Sufficiently in advance of the discharge of a patient from hospital treatment, it will be the usual policy insofar as time permits, to determine whether he will be in a position to carry out the medical recommendations, or whether, unaided, he will fail to do so and soon require rehospitalization. The necessary social work will be accomplished by the time of the contemplated discharge, it being kept in mind that a patient with a nonservice-connected condition is ineligible to further Veterans Administration out-patient social treatment.



6873. TRAVEL FOR MEASUREMENTS AND FITTINGS.—Transportation requests or any meal or lodging requests or mileage allowance in lieu of actual expense necessary to cover round-trip travel of an entitled beneficiary to the points mentioned in R. & P. 6872 may be supplied under R. & P. R-6100 or paid under R. & P. 6074, or a physician or other trained employee may be detailed to measure, adjust or repair orthopedic or prosthetic appliances for a group of beneficiaries in hospital or elsewhere. See also R. & P. 6460 (G) and (H). Note R. & P. 6067 (B) as to readmission to a facility for fitting of an artificial limb. (February 12, 1945.)

6876. FURNISHING AND REPAIR OF APPLIANCES FOR OUT-PATIENTS.—(A) Form 2827, revised, will be executed as an application for an orthopedic or prosthetic appliance. Requests may be made in person or by mail. (See R. & P. 6493.) When a person as defined in R. & P. 6870 (A) and (B)(4) requests the furnishing, repair or replacement of an appliance it must be established that the disease or injury, for which the appliance is medically determined as necessary, is service connected; or, that it is appropriately to be supplied as adjunct treatment for a service-connected disability. When a person as defined in R. & P. 6870 (B)(1) and (3) requests the furnishing, repair or replacement of an artificial limb or brace, etc., it must be established that loss of the limb or use thereof was due to injury or disease incurred or contracted in line of duty in active service. See also R. & P. R-6115 and 6116.

(B) The medical file pertaining to the applicant, if there be one in the station contacted, will be reviewed by the eligibility clerk to note if out-patient service of any kind had previously been rendered. If an orthopedic or prosthetic appliance had formerly been furnished, a Form 2529, Prosthetic Appliances Service Card, will have been placed in that file. If there is no medical file, but the C-file of the applicant is in possession of the station, the clerk will proceed as provided in R. & P. 6494 (D). If the C-file is in possession of another office, central or field, the clerk will take action as prescribed in R. & P. 6494 (E). Inquiry will be made on Form 505 whether an orthopedic or prosthetic appliance had been supplied or repaired for the applicant, and, if so, of what type and at what past date. Employees who complete Form 505 will review, in addition to other records, Forms 2593 in case files to ascertain whether appliances were furnished or repaired during hospital treatment or domiciliary care (see R. & P. 6096). If the applicant has not made any previous claim for either monetary benefit or medical treatment, the clerk at regional offices and facilities with regional office activities will follow the provisions of R. & P. 6494 (C). The clerk at facilities not having regional office activities will refer the request for service to the field station with regional office activities having jurisdiction over the area in which the applicant is located, for development and indicated action. (February 12, 1945.)

(C) When an orthopedic or prosthetic appliance (not including stump socks, or batteries for hearing devices) is furnished, replaced or repaired, the chief medical officer or his designate will have executed Form 2529 in duplicate. The original will be placed in the medical file of the beneficiary; if there is no existing medical file, one will be created. The duplicate Form 2529 will be attached as a supporting exhibit to the voucher for the service. The beneficiary will be required to sign the original and duplicate. If the appliance is not delivered to him in person but is sent to him, the forms will be mailed to his address with the delivered article, with request that he sign them under "Signature of [beneficiary]", and return them to the station. An addressed penalty envelope will be sent him for this purpose.



(D) [Before Form 2529 is disposed of as provided in (C) hereof the entries regarding inspection will be made thereon. Appliances, or repairs thereof, of a major nature such as artificial limbs, spinal and limb braces, hearing aids, cosmetic appliances, new sockets for artificial limbs, etc., will be inspected by a physician unless there are impelling reasons to the contrary. Inspection of other appliances or repairs will be dependent upon the medical judgment of the chief medical officer or his designate. The reason for not making inspection of a major item as above provided or for rejection of an item will be recorded on the reverse of Form 2529 and such statement will be signed and dated by the chief medical officer or his designate.] Whenever possible, the fitting and final approval of an appliance will be effected at a field station, in order that such entries as to inspection may be recorded. But in cases where this procedure is impracticable or would cause undue travel expenditures, the inspection and said entries on Form 2529 may be accomplished at the manufacturer's place of business or may be arranged through a designated physician, or private physician to whom the two copies of that form will be sent for handling in the manner prescribed in (C) hereof and with instructions to return both after their execution.

(E) See R. & P. 6308 for special clothing made necessary by wearing of an appliance.

(F) Beneficiaries and [inspecting] physicians signing Form 2529 will understand that their signatures constitute evidence that the appliance serves the purpose for which it was authorized and meets contract or bid specifications. (October 20, 1945.)

6878. FURNISHING AND REPAIR OF APPLIANCES DURING HOSPITAL TREATMENT OR DOMICILIARY CARE.--(A) Whereas, in out-patient service, an orthopedic or prosthetic appliance can be supplied, replaced or repaired only for a service-connected condition, or (for ex-members of the military or naval service or Coast Guard) as adjunct treatment; and an artificial limb or brace, etc., replacement thereof or repairs thereto may be supplied retired personnel, an appliance may be supplied, replaced or repaired for a beneficiary receiving hospital treatment or domiciliary care not only under the said conditions applying to out-patient treatment, but also without regard to service connection, that is, as auxiliary treatment (see R. & P. R-6115 (D)). Need for the service will be medically determined.

(B) If the service is the first of its kind to be rendered at a facility, it will be ascertained whether a like service had been rendered at another field station. This ascertainment will be applicable to major appliances (especially as to artificial limbs) and major repairs. It will not be applicable to rubber goods or to minor repairs, provided that eligibility has been established beforehand. To develop information as to previous rendition of the needed service, the procedure outlined in R. & P. 6876 (B) will guide. The Form P-10 executed upon the beneficiary's admission should show in what facility or facilities the beneficiary had received treatment or care in the preceding year and the location of the case file. Also all copies of Form 2593 executed and distributed upon a beneficiary's discharge from any facility, Federal, State, or civil hospital will show under "Remarks" whether an appliance of a permanent type had been supplied. But, pending development of such information, the patient may be supplied such temporary appliance, station property, as is necessary for his treatment or care.

(C) If it is determined that a beneficiary is entitled to an appliance, the ward physician (if the beneficiary is receiving hospital treatment) or the physician attending a member (if the beneficiary is a member in domiciliary status) will state the appliance desired, on Form 2614j, Clinical Record, with the certification "Determined as necessary treatment of a service-connected condition (specify condition)", or "Determined necessary as adjunct treatment", or "Determined necessary as auxiliary treatment", as the case may be. The Form 2614j bearing such identification of appliance and physician's certification will be forwarded to the chief medical officer or clinical director, who will date and endorse it "Approved" or "Disapproved", as he decides, followed by his signature. If the Form 2614j, returned to the ward physician or physician attending a domiciliary member, is endorsed "Approved", pro-

(6878 Continued.)





curement of the appliance will be proceeded with (see R. & P. 6882). Form 2529, Prosthetic Appliances Service Card, will be executed in duplicate, signature to both being obtained from the beneficiary; except that if the beneficiary be mentally incompetent, the ward physician or attending physician is authorized to sign Form 2529, adding beneath his own signature the statement "For (name of beneficiary) who is incompetent". The duplicate of Form 2529 will be attached to the voucher for the appliance. The original will be placed in the clinical records if the beneficiary be a hospital patient, and in the treatment file if the beneficiary be a domiciled member (see R. & P. 6109). The Form 2614j, if executed by a ward physician, will be placed in the clinical records of the patient; if executed by a physician treating a domiciled member, in the member's treatment file. Chief medical officers and clinical directors will be expected to give close attention to the necessity of proper economy in the furnishing of appliances to patients and members. (February 12, 1945.)

(D) If the facility has no contract covering the required type of service, the manager of the regional office or facility with regional office activities of the territory will be asked to supply the name and address of a manufacturer who may be under contract with him, and who could supply or repair an appliance. Workshops of the Veterans Administration will be kept in mind (see R. & P. 6872).

(E) For notation upon Form 2593, when a beneficiary is discharged from hospital treatment or domiciliary care, see (B) hereof. (October 31, 1938.)

(F) For artificial limbs and hearing devices or repairs to either at a cost in excess of \$25.00 not authorizable for domiciled members for treatment of a service-connected disability or adjunct thereto, see R. & P. R-6115 (D)(3).

(G) Persons maintained in State soldiers' homes are not entitled to prosthetic or orthopedic appliances except for treatment of a service-connected disability or as adjunct thereto, regardless of whether Federal aid payments are authorized by the Veterans Administration. (February 12, 1945.)

6879. APPLIANCES AND REPAIRS THERETO FOR BENEFICIARIES IN ARMY, NAVY, PUBLIC HEALTH SERVICE OR CIVILIAN HOSPITALS.--Chief medical officers or their designates in the regional office or facility with regional office activities having jurisdiction of the territory concerned will follow the procedure outlined in R. & P. 6878 (A) and (B) in determining the eligibility of patients of the Veterans Administration receiving authorized treatment in such hospitals for the furnishing or repair of an orthopedic or prosthetic appliance. Their consideration will be based upon requests from commanding officers, medical officers in charge or superintendents for the service. Form 2529 will be executed and disposed of as provided in R. & P. 6876 (C). For notations on Form 2593, upon discharge, see R. & P. 6096. (February 12, 1945.)

6880. OBTAINING PROPOSALS TO FURNISH APPLIANCES.--(A) See R. & P. 8117 which specifies the kinds of orthopedic and prosthetic appliances for which central office will solicit proposals, and the kinds which managers of field stations are authorized to contract for and purchase. Particularly to be noted is the requirement in R. & P. 8117 (D) and (E) that all proposals for optical, orthopedic and prosthetic appliances shall incorporate a guarantee that if, within 60 days after delivery, the appliance is found unsatisfactory, due to imperfect fit or faulty construction, it will be corrected or replaced by the contractors and a provision whereunder the bidder may offer a discount for payment within thirty (30) days only. (February 12, 1945.)

(B) The number of contractors for any regional territory must be sufficient in number, and distributed geographically to such advantage, that the convenience of beneficiaries and economy in transportation expense incident to measurement and fitting, repair, etc., may be served. (October 31, 1938.)



6881. MANAGER'S AUTHORITY TO EFFECT PURCHASES ON CENTRAL OFFICE CONTRACTS.--The director of supplies will forward managers of field stations a copy of the contracts which have been solicited and accepted by central office. When thus informed, chief medical officers or clinical directors and their physician designates may initiate the purchase of any type of appliance covered by such contracts. (February 12, 1945.)

6882. FORMS TO BE USED IN SUPPLY OR REPAIR OF AN APPLIANCE.--(A) The following forms will be used in supply or repair of an orthopedic or prosthetic appliance, whether for beneficiaries under R. & P. 6870 (A) or (B).

(1) Form 2529, Prosthetic Appliances Service Card. For preparation, see R. & P. 6876 and 6878. See also R. & P. 4308.

(2) Form 2237, Request for Supplies not Carried in Stock or Services, will be prepared by the field station, in duplicate, both to be signed by the chief medical officer, clinical director, or physician designated by either for this duty. The copy will be placed in a medical file if the service was out-patient, or in the correspondence file if the service was rendered a beneficiary receiving hospital treatment or domiciliary care. The original will be routed to the supply officer.

(3) Form 2504, Decision of Questions of Fact and Law, will be prepared in duplicate, both to be signed as provided in (2).

(4) Form 1252, Purchase Order, will be prepared and signed by the supply officer in stations where such employee is on duty. In stations where there is no supply officer on duty, and where the manager has been designated the conduct of supply matters, the physician concerned, under direction of the manager, will prepare a Purchase Order, Form 1252, to be initialed by the chief medical officer or clinical director, and referred to the manager for signature. Before distribution, all purchase orders will have placed on them the authorization and procurement numbers. Purchase Order, Form 1252, will be prepared as an original and five tissue copies. The original goes to the vendor; two copies are to accompany the voucher; one copy goes to the finance officer; one to the purchase order file; and one to the storekeeper (with both copies of Form 135).

(5) Form 135, Invoice and Receipt for Property Purchased, will be prepared (at stations where the manager is handling supply matters) in duplicate; one for the station property voucher file, the other copy to the procurement section for attachment to the fiscal voucher. See also R. & P. 8032 and 8033.

(B) (1) Form 2529, in duplicate, the original Form 2237 and Form 2504, in duplicate, prepared and signed as provided in (A) will be routed to the supply officer for procurement of the service.

(2) When delivery of the appliance is made, the appliance and Form 2529, in duplicate, will be forwarded to the chief medical officer, clinical director or physician designate of either for inspection, approval and acceptance of the appliance. Form 2529 will be completed by securing the signatures of the beneficiary and inspecting physician, and the signed duplicate of the form will be returned to the supply officer as support to the voucher for the service. See also R. & P. 6876 (F), 6878 (C), 4298 and 4311. (February 12, 1945.)

6884. PURCHASE OF AN APPLIANCE NOT COVERED BY CONTRACT.--(A) When it is necessary to provide an appliance (other than artificial limb or hearing device) which is not covered by contract, a field station, as provided in R. & P. 8117 (C), may authorize its purchase, if the cost does not exceed [\$100]. But if the cost of such appliance is more than [\$100], the chief medical officer or clinical director will submit the estimate



6889. HEARING DEVICES.--(A) Many persons who are only partially deaf do not require a hearing device, will not procure one unless persuasive selling arguments are used, and often will discontinue the wearing of such a device after they have procured it. These partially deaf persons have learned to get along satisfactorily without audition appliances, through readily acquired lip reading. The Association for Hard of Hearing, an organization with a true interest in deaf persons, recommends lip reading for most of such individuals. (February 12, 1945.)

(B) When request is made for a hearing device by an entitled applicant, the physician in charge of the treatment will determine whether the applicant is in need of an audition appliance. The physician making this determination will be one, an aurist wherever possible, who has knowledge of the underlying pathology of the applicant's condition. If he determines that the applicant needs a hearing device and that it would be helpful, the devices of the different contractors will be tried out on the applicant. The applicant will be permitted to state in writing what device he thinks best suits his requirements at these try-outs, but the ultimate decision as to what type of device is indicated will rest with the examining physician.

(C) Accepted proposals will contain the agreement of the bidder that he will neither directly nor through his agents solicit beneficiaries, but will confine these activities to the responsible officers of the various facilities and regional offices. However, the agent or representative of each contractor may be permitted to demonstrate his appliance at the various stations of the Veterans Administration, so that the responsible physicians may be familiar with its advantages.

(D) Accepted proposals for furnishing hearing aids to beneficiaries of the Veterans Administration will contain the agreement of the bidder to make suitable models available for use in selection of the instrument most adaptable to the needs of each beneficiary. This condition of the contract is not to be construed as meaning that each contractor will be called upon to stock a complete line of his accepted instruments. Adequate compliance with this requirement will be made if each contractor makes available a standard model with combination air and bone conduction equipment or, upon request, loans a suitable model for use in testing each case.

(E) In observing the conditions in (B) hereof, the physician in charge of the deaf patient may feel free to call upon the representatives of the various contractors for the proper adjustment of an appliance handled by them, or for assistance in demonstration of an appliance, etc.

(F) The provisions of R. & P. 6885 and 6886 will be applicable to hearing devices. (October 31, 1938.)

(G) Hearing devices which are replaced within four years of the date of purchase, due to progression of deafness rendering the device no longer suitable to meet the needs of the beneficiary will be retained and placed in a satisfactory condition for issue to an eligible beneficiary. Report of such hearing aids surplus to station needs will be submitted to the medical director. (February 12, 1945.)

6890. BATTERIES FOR HEARING DEVICES.--Chief medical officers or their designates (chiefs, out-patient service, etc.,) will make, quarterly, by use of Form 2846a, a determination of actual requirements for supply of batteries for hearing devices to entitled beneficiaries. Batteries will be provided in accordance with individual needs, with determination of the cell and volts and requirements in each case. Purchase and shipments to beneficiaries will be made as provided in R. & P. 6888 for stump socks, and a corresponding notation will be made in the medical files of the



beneficiaries so supplied. An entitled beneficiary who calls in person at the station may, however, be supplied such batteries as are judged necessary, in lieu of the amount that would have been furnished by mail for the period of three months. (February 12, 1945.)

6891. ORTHOPEDIC SHOES.--Special orthopedic shoes will not be supplied for pes planus or other minor foot conditions. The entitled beneficiary's personally-owned shoes will instead, be modified as required at expense of the Veterans Administration. Entitled beneficiaries suffering from marked deformity of the feet, who cannot be fitted satisfactorily with stock shoes, or whose own shoes cannot be satisfactorily altered, may be supplied special orthopedic shoes. In no circumstances will corrective shoes available to the general public be supplied at Government expense. (October 21, 1938.)

6892. FURNISHING OF AN APPLIANCE TO A BENEFICIARY WHO HAS LEFT A FACILITY.--(A) The medical determination of need of an orthopedic or prosthetic appliance of any kind, as defined in R. & P. 6870, for an entitled beneficiary receiving hospital treatment or domiciliary care, will be made, and such appliance procured and fitted, at a time sufficiently in advance of the contemplated date that such beneficiary is to leave the facility either by discharge (regular or irregular), transfer, trial visit or furlough. This economic necessity will be particularly impressed, by managers of regional offices and facilities with regional office activities, upon commanding officers, medical officers in charge of other Federal hospitals and superintendents of contract hospitals.

(B) Any orthopedic or prosthetic appliance that was properly authorized and procured for a beneficiary while receiving hospital treatment or domiciliary care, but was not delivered before the beneficiary left a facility, cannot be shipped (or mailed) to the beneficiary at the place of residence, except where the appliance is for treatment of a service-connected disability. In such case, if fitting is necessary, it can be accomplished at the facility, or the service can be referred to a regional office, if closer to the beneficiary's place of residence. If such beneficiary had received a regular discharge from the facility, transportation to cover fitting at the station selected can be supplied. If the patient or member has been discharged or put on enforced furlough because of an offense against facility discipline, transportation to effect fitting may not be authorized. (February 12, 1945.)

(C) When such appliance was authorized and procured for a disability not service connected, delivery or fitting thereof can be made only upon formal readmission of the beneficiary for hospital treatment or domiciliary care medically determined as necessitated for a disease or injury, and in accordance with provisions governing readmissions to facilities; or delivery and fitting of an appliance so procured may be made if the beneficiary deposits with the manager of the regional office or facility having jurisdiction of his territory of residence, an amount to cover actual cost of the appliance to the Veterans Administration, plus cost of shipment of the article. (October 31, 1938.)

6893. FURNISHING OF WHEEL CHAIRS UPON DISCHARGE FROM HOSPITAL TREATMENT OR DOMICILIARY CARE FOR A NONSERVICE-CONNECTED CONDITION.--[A regular or folding wheel chair may be supplied for permanent use at home by a beneficiary suffering from a nonservice-connected condition, who is about to receive a regular discharge following completion of hospital treatment or domiciliary care, provided it is medically determined that such beneficiary's physical condition at such time requires the permanent use of a wheel chair at home after discharge and a statement showing the need and reasons therefor is approved by the chief medical officer or clinical director. When the beneficiary is receiving authorized hospital treatment in a hospital other



than one under direct and exclusive jurisdiction of the Veterans Administration, such statement will originate with the commanding officer, medical officer in charge or superintendent of such other hospital and will be approved by the chief medical officer or his designate of the regional office or facility with regional office activities concerned. Examples of physical conditions for which a wheel chair can appropriately be recommended in these circumstances are: Bilateral amputations of legs with inability to use artificial limbs; bilateral paralysis of legs, advanced arthritis, making walking impossible, and not suitable for braces; advanced encephalitis; advanced cardiac or cardiorenal disorders requiring continuous confinement to bed or wheel chair. Wheel chairs supplied under the foregoing conditions will not be furnished upon memorandum receipts, subject to return as station property, but will be dropped at time of issue on credit voucher, Form 136. Wheel chairs furnished under the provisions of this paragraph for a nonservice-connected condition may not be repaired or replaced at the expense of the Veterans Administration. Wheel chairs sufficient to meet estimated needs will be procured by requisition in the usual manner. (For furnishing of wheel chairs for an out-patient with a service-connected disability, see R. & P. 6512 (B).] (September 12, 1945.)

#### GUIDE DOGS OR MECHANICAL AND ELECTRONIC EQUIPMENT FOR BLIND BENEFICIARIES

6895. FURNISHING OF GUIDE DOGS OR MECHANICAL AND ELECTRONIC EQUIPMENT FOR BLIND BENEFICIARIES.--(A) See R. & P. R-6118. Application for a guide dog will be made by the veteran or a representative of the veteran upon form titled "Application for Guide Dog", in triplicate. If the request be made while the veteran is hospitalized, domiciled, or at an out-patient unit, a contact representative or medical officer may act as the applicant's representative in executing the form. If the request be made in a letter from the veteran, Form 2630 will be forwarded with instructions for its completion and return. Upon execution, the form, original and two copies, will be routed to the adjudication officer of the station in possession of the case file of the applicant, who will complete the statement regarding entitlement to disability compensation or pension and return them.

(B) Upon return from the adjudication officer, the forms will be routed to the chief medical officer or clinical director who, if potential eligibility is shown, will determine whether, because the blindness is wholly functional or the applicant is mentally incompetent or temperamentally unsuited, it is inadvisable to furnish a guide dog. This determination may be made from the certification of the adjudication officer, from the case file, which may be procured if it is not available, from personal knowledge of the applicant's condition if he had been hospitalized, domiciled or treated as an out-patient; or by authorizing the applicant to report for an interview.

(C) Should determination be made that favorable consideration may not be given to furnishing a guide dog, the reasons therefor will be entered on the original application, Form 2630, and the applicant will be advised of the disapproval. The original application will be filed in the correspondence file if the applicant is receiving hospital treatment or domiciliary care, or in the medical file if an out-patient. If there are no such files, the original application will be placed in a manila folder, retained one year and then reported as an inactive record. The copies of the form may be destroyed.



(D) Should determination be made that consideration be given to furnishing a guide dog, the applicant will be interviewed by the chief medical officer or clinical director (or designate of either) and the training officer for the blind, at the nearest regional office or facility with regional office activities. Should the decision be favorable, the chief medical officer or clinical director will also determine whether the applicant is a veteran of World War II with entitlement under Public Nos. 16 or 346, 78th Congress, and is pursuing or intending to pursue vocational rehabilitation or education thereunder, in which case he may invite collaboration with the training officer for the blind in order that the introduction of the dog (if the use of such is compatible with the veteran's training, employment or job objective) may be made at the appropriate time; and the essential facts, including indication of the appropriate time for supplying the guide dog, will be reported to the director of supplies who will designate the point for adjustment to the dog and issue instructions regarding transportation to and from that point, the costs involved for adjustment, training, and maintenance of the beneficiary during the period of adjustment and the cost of the trained dog. It will be explained to the applicant that if suitable adjustment to the guide dog is accomplished, the guide dog furnished becomes his property and, by ownership, he will be responsible for the feeding of the dog, the procurement of and payment for license tags, if required, and liability for damages for injuries inflicted by the dog. Form 2630, in triplicate, will be forwarded to the manager having jurisdiction over the territory where the adjustment is accomplished for authorization, completion of certification on the form by the beneficiary, contractor, and a representative of the Veterans Administration, and for vouchering of the costs involved. The original Form 2630 will be attached to the voucher, one copy will be filed in the correspondence or out-patient file and the remaining copy will be filed or forwarded for filing in the claims file.

(E) Necessary medical care and treatment of guide dogs by veterinarians at fees not in excess of those charged the general public may be authorized.

(F) Guide dogs lost without negligence on the part of the beneficiaries may be replaced, provided eligibility thereto still exists.

(G) MECHANICAL AND ELECTRONIC EQUIPMENT.—Request for mechanical and electronic equipment for an eligible blind ex-serviceman will receive consideration by the persons enumerated in subparagraph (D) above. Personal interviews with the applicant will not be arranged unless the circumstances warrant.

(H) Encumbered "C" requisitions for mechanical and electronic equipment for eligible blind veterans shall be forwarded to the director of supplies. Each requisition shall show the name and C-number of the veteran and the purpose for which the veteran proposes to use the equipment.

(I) Replacements of mechanical and electronic equipment will be made in accordance with current instructions governing replacements of orthopedic or prosthetic appliances, when necessity for replacement is not caused by negligence of the beneficiary. (May 14, 1945.)

PENSIONERS OF NATIONS ALLIED WITH THE UNITED STATES IN THE WORLD WAR WHO ARE RESIDENTS OF THE UNITED STATES.

PHYSICAL EXAMINATION AND TREATMENT OF PENSIONERS OF NATIONS ALLIED WITH THE UNITED STATES IN THE WORLD WAR, WHO ARE RESIDING IN THE UNITED STATES.

7500. DEFINITIONS.—(A) The term "Administration" in the subjoined instructions will mean the Veterans Administration, Washington, D. C.

(B) "Central office" will mean the central office, Veterans Administration.

(C) "Medical director" will mean the medical director (attention of insular and foreign subdivision), Veterans Administration, Washington, D. C.

(D) "Department" will mean, in the case of Canadian ex-service men, the Department of Pensions and National Health, Ottawa, Canada. In the case of British Imperial ex-service men, reference to the "Department" will be construed as referring to the British Ministry of Pensions, Ottawa, Canada.

(E) A "Canadian beneficiary" will mean and include any retired officer or discharged enlisted man of the naval and military forces of Canada, the Commonwealth of Australia, the Dominion of New Zealand, and the Union of South Africa, who had service in the World War. It will not mean an ex-member of the naval or military forces of the Dominion of Newfoundland, nor of other nations allied with the United States in the World War.

(F) An "Imperial or British beneficiary" will mean and include any ex-member of the military, air or naval forces of the United Kingdom of Great Britain and Ireland who is suffering from a disability attributable to or still aggravated by the continuing effects of service in the World War. The general procedure hereinafter outlined for Canadian beneficiaries will be applicable to Imperial or British beneficiaries, but the administration of such procedure is conducted through the Ministry Representative, British Ministry of Pensions, Canadian office, Ottawa, Canada.

(G) A "Newfoundland beneficiary" - See R. & P. 7593.

(H) Other Beneficiaries.—Ex-members of the military or naval forces of nations allied with the United States in the World War, other than those hereinbefore specified, may be given such physical examinations or medical treatments as are arranged for, with guarantee of expense involved, between the embassies and ministries of such other countries and the medical director of the Veterans Administration. (March 31, 1937.)

7501. RESPONSIBILITY OF DEPARTMENT.—The Department (the British Ministry of Pensions in the case of British Imperial Beneficiaries) is responsible for the provision of treatment to Canadian or British Imperial beneficiaries resident in the United States, when such treatment is required in respect of conditions related to military service in the World War. (March 31, 1937.)

7502. IDENTITY OF APPLICANT.—When an individual claiming to be a Canadian or British Imperial beneficiary presents himself for physical examination or medical treatment to a medical officer of the Veterans Administration, that officer will first satisfy himself from documentary evidence of the identity of the applicant. He will state in his report (see R. & P. 7570) the means of identification, and also if possible ascertain, either from the available records in the field station or from documents in the applicant's possession, the nature of the accepted service disability. (March 31, 1937.)



7503. [AUTHORIZATION FOR SERVICE TO BE OBTAINED WHEN A BENEFICIARY VOLUNTARILY PRESENTS HIMSELF.—If a British Imperial beneficiary voluntarily presents himself to a medical officer in a field station of the Veterans Administration, no physical (either ordinary or special) and no laboratory examination will be made, and no medical treatment will be provided, unless specifically authorized by the British Ministry of Pensions. The only exceptions to this rule are set out in R. & P. 7513, 7514 and 7515. If a Canadian beneficiary so presents himself an examination may or may not be conducted at the option of the medical examiner, determinable by evidence of identity and service-connected disability, but no special, laboratory or X-ray examination will be carried out without definite authority from the Department, but medical treatment may be provided in accordance with R. & P. 7514 (A).] (March 20, 1939.)

7504. SERVICE WHEN A BENEFICIARY PRESENTS HIMSELF UNDER AUTHORITY.—If a Canadian or British Imperial beneficiary presents himself for physical examination at a field station of the Veterans Administration, upon authority, the examination will be conducted in accordance with the terms of the authority, that is, ordinary or general examination, specialistic, laboratory procedures, as authorized. But if the terms of the authority do not specify the type of examination, an ordinary or general examination will be made, together with any special examinations or laboratory procedures that, in good medical judgment, are necessary to arrive at a correct diagnosis. (March 31, 1937.)

7505. HOSPITAL OBSERVATION AT INSTANCE OF ADMINISTRATION.—If, in the opinion of a medical officer of the Veterans Administration, a Canadian or British Imperial beneficiary referred for out-patient examination requires a period of hospital observation to establish a diagnosis, such hospital observation will not be effectuated until authority therefor has been requested and obtained from the Department or medical director. (March 31, 1937.)

7506. HOSPITAL OBSERVATION AT INSTANCE OF DEPARTMENT.—If a request is received from the Department or medical director that a Canadian or British Imperial beneficiary be admitted to a facility for intensive hospital observation, such admission will be effectuated, the full required study made, and a full report thereof submitted promptly to the Department, through the medical director. (March 31, 1937.)

7507. REPORT OF PHYSICAL EXAMINATION.—Forms furnished by the Department will, if available, be used for reports on Canadian or British Imperial beneficiaries. Examining physicians will set forth in such reports the nature of the disabling condition, the symptoms complained of, the physical signs of the disease, the treatment required, if any, the probable duration of such treatment, and the capability of the beneficiary to carry on a gainful occupation while under such treatment. Even when it does not appear to the examiner that the disabilities are related to military or naval service, a report will nevertheless be made. If the man be suffering from two or more pathological conditions, these will be shown in the order of importance, and the pathological conditions for which treatment is required will be clearly indicated together with the form of treatment recommended (hospital or out-patient). Percentage of disability is not to be estimated unless requested by the Department. If plain paper be used for a report, it will be captioned, "Examination of a Canadian Beneficiary," or "Examination of a British Imperial Beneficiary," respectively. Reports of physical examination will be in quadruplicate. One carbon copy will be retained at the regional office or facility at which the examination was made. The original and two copies will be forwarded to the medical director, attention foreign and insular subdivision. A carbon copy will be retained by that subdivision, and the original and a carbon copy transmitted to the Department. (March 31, 1937.)



7508. [REPORTS OF EXAMINATION CONFIDENTIAL.--All reports of the physical examination of Canadian or British Imperial beneficiaries are to be treated as strictly confidential. In no circumstances is the beneficiary to be given a certificate indicating his percentage of disability.] (March 31, 1937.)

7509. [NO RE-EXAMINATION WITHOUT FURTHER AUTHORITY.--If a Canadian or British Imperial beneficiary has been examined and rejected as ineligible for benefits, he will not again be examined unless a request therefor be received from the Department or medical director. If he wishes to substantiate his claim, he may forward, direct to the Department, a certificate from his private physician, obtained at his own expense, and any other evidence he may wish so to submit.] (March 31, 1937.)

7510. [EXAMINATIONS OTHER THAN AT FIELD STATIONS.--If the physical condition of a Canadian or British Imperial beneficiary forbids his travel to and from the nearest field station, the chief medical officer receiving request from the Department or medical director for his examination may authorize the service by a designated physician in the community of the beneficiary's place of residence, at a fee in accordance with the current schedule of fees, Veterans Administration. However, if such beneficiary is residing at a location sufficiently near the field station concerned so that it would be more economical and convenient to send a physician from the field station to the home of the beneficiary, that procedure, rather than employment of a designated physician, may be followed.] (March 31, 1937.)

7511. CERTIFICATE AS TO TIME LOST.--When a Canadian [or British Imperial] beneficiary reports under the direction of an officer of the Department or an officer of the Veterans Administration for medical examination, there will be attached to the report a statement of the time lost from work in traveling by the most direct route to and from his home and for the actual time lost from work through being detained at the place where he is directed to report. The statement will also indicate whether transportation and subsistence (meals and lodging) have or have not been provided. Any amount which the man may be entitled to will be paid to him direct by the Department. The following form may be used.

#### REPORTS AND RECORDS

(Name, number) who was instructed to report at \_\_\_\_\_ for \_\_\_\_\_ was required to absent himself from his home from \_\_\_\_\_ a.m. (p.m.) (date) to \_\_\_\_\_ a.m. (p.m.) (date) and therefore lost \_\_\_\_\_ day (days) \_\_\_\_\_ hours from work. Transportation was (was not) provided and he has (has not) been furnished with subsistence.

\_\_\_\_\_, EXAMINING OFFICER.

(March 31, 1937.)

7512. FAILURE TO REPORT FOR EXAMINATION [ ].--If the Department has requested a report upon a Canadian [or British Imperial] beneficiary with a view to treatment or pension and such beneficiary refuses or fails to present himself for examination, the Department will be notified through central office of his refusal or failure with the reasons therefor if known. (March 31, 1937.)

7513. [APPLICATION FOR TREATMENT.--When a Canadian or British Imperial beneficiary applies for treatment, the medical officer handling the applicant will first ascertain if any record pertaining to the applicant's case is on file in the field station contacted. If there is such record, it will be determined whether it contains a definite statement regarding the applicant's accepted disabilities, and whether the treatment for which application is made has been authorized by the Department. If these conditions are met, treatment, in hospital or on out-patient



status, will be provided, with report of details to the medical director. Designated physicians, part-time or fee-basis, will be instructed by chief medical officers that they are not empowered to render treatment to a Canadian or British Imperial beneficiary applying directly to them, until they have secured authorization for the service.] (March 31, 1937.)

7514. [TREATMENT.--(A) No treatment of any kind will be provided a Canadian or British Imperial pensioner unless the treatment is or has been specifically authorized by the Department, with the exception of the rare cases of actual medical emergency in which delay in the provision of treatment would endanger the life of a pensioner suffering from an accepted disability.

(B) Field stations will communicate direct with the Department if necessary, by telegraphic night letter, collect, when application is received for treatment from such beneficiaries, and the field station contacted has no recent or current authority in its files for provision of treatment in the case. A copy of such direct communication to Ottawa will be forwarded to the medical director.

(C) When communicating with the Department, in cases where the reference number of the applicant is not known to the field station of the Veterans Administration which is contacted by him, it is essential that adequate identifying data be supplied. These should include, in all cases, the surname, first and middle names of the applicant, and his regiment or unit and regimental number (or rank, if an officer). In the case of initial applications, these additional particulars should be added: The date of discharge from military or naval service; the cause of discharge (disability, etc.); and whether the applicant had formerly been in receipt of a pension and, if so, for what disability, and when the pension ceased.] (March 31, 1937.)

[7515. EMERGENCY TREATMENT.--If a Canadian or British Imperial beneficiary presents himself for or is reported to require emergency treatment because of an exacerbation of a condition known to be or established by documents in his possession to be his accepted service disability, or recognized as being obviously secondary to some definite service injury, the medical officer may give emergency treatment or may order the applicant to hospital without waiting for authority. Full details of the condition and of the action shall be forwarded immediately to the medical director for transmission to the Department. When the condition necessitating treatment is not known or established by documents to be an accepted service disability and is not obviously secondary to some definite service injury, no treatment may be given and no expenses will be incurred though the emergency nature of the case is fully established. All papers and documents filled out for patients taken on emergency strength without specific authority will be stamped "Emergency."

(A) In emergency cases of Canadian or British Imperial beneficiaries where expeditious furnishing of relief is indicated, the regional office or facility contacted by the applicant will communicate directly with the Department, giving full data as to the name, regiment or unit and regimental number (or rank, if an officer), and the nature of the disease or injury necessitating emergency treatment of the applicant, and requesting to be informed as to his eligibility for treatment on an emergency basis. The Department will reply directly to the field station making the inquiry, which will proceed in accordance with the information supplied.



(B) The field station will transmit to the medical director a copy of the telegram which was sent to the Department. The Department receiving a telegram of this character will similarly forward to the medical director a copy of its reply to the field station.

(C) The procedure outlined herein will be solely within the authority of regional offices or facilities of the Veterans Administration. No other relief agency will be authorized or will be requested in any way to communicate with the Department, nor will such Department recognize any letters or telegrams regarding such beneficiaries unless such communications emanate from a field station or from the medical director.

(D) The procedure authorized herein will apply solely to such beneficiaries concerning whom a prompt reply on the eligibility is necessitated because of an actual emergency. Emergency cases are the only ones in which direct contact by a field station with the Department is authorized. In any other type of relief for these beneficiaries the procedure will require that all communications with reference to authority for treatment be addressed to the medical director, who will take the question up with the proper agency in Canada, and instruct the field station concerned upon the basis of authority received.] (March 31, 1937.)

[7516. CERTIFICATE IN EMERGENCY TREATMENT CASES.--When emergency treatment is granted a Canadian or British Imperial beneficiary by a physician of the Veterans Administration a certificate signed by the chief medical officer shall be submitted to the medical director showing the disability, the nature of the emergency condition, and the respect in which it is considered to be undoubtedly related to military service. If such certificate can not be secured, the case will be referred to the medical director, who will take the necessary action to obtain from the Department the authority for the treatment.] (March 31, 1937.)

[7517. PLACE OF TREATMENT.--In all ordinary circumstances Canadian or British Imperial beneficiaries resident in the United States will be treated therein. Transfer to Canadian institutions will be carried out in very exceptional instances, and then only when arrangements have been initiated and made by the Department.] (March 31, 1937.)

7518. HOME TREATMENT.--If in the opinion of the medical officer the patient's life will be jeopardized by removal to a [facility] he may be treated at home until such time as he may without danger be removed to a [facility] and in such cases the medical report will contain a statement of the circumstances which prevent his removal to [a facility]. (March 31, 1937.)

7519. [TREATMENT FOR TUBERCULOSIS.--Canadian or British Imperial beneficiaries who are suffering from tuberculosis, and who are eligible under Departmental regulations to receive sanatorium treatment at the expense of Canadian or British public funds, may be placed in a sanatorium, but authority therefor must in all cases first be obtained from the Department or medical director, unless such authority, still in force, has previously been issued.] (March 31, 1937.)

7520. [INSANE PATIENTS.--If application for hospitalization is made by or on behalf of an insane ex-member of the Canadian or British Imperial forces, the case should be referred to the civilian authorities for legal commitment, and the Department notified by telegram. The Department will then consider the question of financial responsibility or further action.] (March 31, 1937.)



7521. **[INSANE PATIENTS--REPORT ON DEPENDENTS.**--In order that the dependents, if eligible, of an insane Canadian [or British Imperial] beneficiary may, during the time he is in a hospital in the United States, be granted an allowance under the regulations of the Department, the Veterans Administration will, on request from the Department, obtain the necessary particulars and certificates for such dependents, including D.P.N.H. Form 185. (March 31, 1937.)

7522. **[HOSPITALIZATION IN FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.**--A Canadian or British Imperial beneficiary may be admitted not only to facilities under direct and exclusive jurisdiction of the Veterans Administration, but also, if such facilities are not feasibly available, to other Veterans Administration facilities as defined in Veterans Regulation No. 10, paragraph XIX, that is, hospitals of the Army, Navy, Public Health Service, or St. Elizabeth's Hospital, Washington, D. C., or civilian hospitals under contract.] (March 31, 1937.)

7523. **[NOTICE OF TREATMENT.**--Immediately a Canadian or British Imperial beneficiary begins treatment, hospital or out-patient, the manager of the field station concerned will notify the medical director of the fact, on the appropriate form provided. The medical director will, in turn, forward the report to the Department.] (March 31, 1937.)

7524. **AMBULANCE SERVICE.**--Officials of the Veterans Administration are authorized to engage private ambulances, when necessary, for the purpose of conveying Canadian [or British Imperial] beneficiaries to hospitals for treatment of an accepted service connected disability, and accounts certified as to the correctness of the charge and the necessity for such expense will be forwarded to the central office for payment. (March 31, 1937.)

7525. **[OUT-PATIENT TREATMENT.- CANADIAN BENEFICIARIES.**--If a Canadian beneficiary requires, for his accepted disability, occasional treatments which do not necessitate admission to hospital, he will be entitled to out-patient treatment and such medicines and supplies as are determined as necessary. Report of such patients will be made at the end of each month to the medical director, on a plain sheet, giving name, regiment or unit and regimental number (or rank, if an officer), and specifying "Canadian Beneficiary", nature of disability, number and kind of treatment. If by reason either of frequency of such treatment or nature of the condition, the beneficiary is unable to pursue an ordinary vocation for a sufficient number of hours each day to support himself and his dependents, this fact, together with a complete description of his condition, shall be included in the report, so as to make clear the reason for inability to follow employment.

(A) **CANADIAN AND BRITISH IMPERIAL BENEFICIARIES.**--In cases of Canadian and British Imperial beneficiaries the number of and periods of out-patient treatment rendered must be limited in accordance with the authority issued by the Department. Treatment must also be limited to the accepted disability and the continuing effects of war service, excluding other factors. The Department does not recognize any adjunct treatment, and the fact that a second condition is regarded as aggravating a pensionable disability will not justify the provision of treatment for the second condition.] (March 31, 1937.)



7526. SERVICE IN GREAT WAR (WORLD WAR) ESSENTIAL.—Should an application for treatment be received from a person who did not see service in the Great War, the application together with such evidence as he may desire to submit, will be forwarded to the Department direct. No treatment or other benefits will be accorded to him without authorization from the Department. (See R. & P. 7561).

7527. REFUSAL OF TREATMENT.—Every case of refusal of treatment will be immediately reported by the manager of the field station of the Veterans Administration concerned to the medical director, with a statement of the reasons given by the [pensioner] for his refusal to accept treatment and [the action taken by medical officers at the field station to persuade him] to accept or continue treatment. This report should state whether or not in the opinion of the medical officer in charge of the case the refusal is reasonable or unreasonable and will if practicable be sustained by the statement of additional witnesses. The statement of the refusal of treatment should be signed by the [pensioner.] Misconduct in hospital resulting in dismissal will be deemed to be unreasonable refusal to continue treatment. (March 31, 1937.)

7528. [PAROLE OR FURLOUGH.—If, in the opinion of the chief medical officer or clinical director, where a Canadian or British Imperial beneficiary is receiving hospitalization in a facility under direct and exclusive jurisdiction of the Veterans Administration; or, in the opinion of the chief medical officer of the regional office or facility with regional office activities of the territory, where such beneficiary is receiving treatment in another Government or civil contract hospital, it is advisable that such beneficiary should be allowed to proceed to his home for a period of out-patient treatment, or on furlough or parole, and no charge is made against the Department for hospital treatment, an extra allowance may be granted by the Department to the beneficiary. In order that he may have the benefit of this allowance all absences of more than a day will be reported to the medical director, stating whether or not it will be necessary to charge the hospital maintenance during period of absence.] (March 31, 1937.)

7529. [AUTHORIZED LEAVE FROM FACILITY.—(A) When a Canadian or British Imperial beneficiary leaves a hospital on authorized leave of absence, the Department will be immediately notified as to the actual date he goes on leave, the kind of leave granted, and the period for which the Veterans Administration will charge for hospitalization.

(B) This notification of grant of leave from hospitalization will be forwarded by letter or telegram, direct to the Department, by the manager of the facility or regional office concerned, who will also inclose a copy of such letter or telegram in a confirmatory communication to the medical director.

(C) Managers of regional offices and facilities with regional office activities will request commanding officers of other government, and superintendents of civil contract hospitals to cooperate promptly in advising them when a Canadian or British Imperial beneficiary proceeds on permitted leave, so that the letter or telegram sent to the Department shall be accurate as to the fact that the beneficiary had left the hospital.] (March 31, 1937.)

7530. [COMPUTING CHARGES FOR HOSPITALIZATION.—(A) Charge (on Veterans Administration Finance Form 1082) for hospitalization of Canadian or British Imperial beneficiaries in facilities under direct and exclusive jurisdiction of the Veterans



Administration, at the per diem rate of \$3.75 will include the day of admission; the day on which a beneficiary leaves the facility on permitted leave; one day subsequent to the day he leaves a facility without permission; and the day of his return from such absence, regardless of the hour of his departure or return. The day of his inter-facility transfer, if any; and the date of his discharge; by death or otherwise, will be omitted from such charges. No fractional part of a day will be considered. Reports will cover hospitalization furnished during one calendar month only. If a beneficiary is absent on leave during any part of a month there will be indicated, in the space provided for the purpose on the form the day and hour of his departure and the day and hour of his return, and whether or not the leave was approved. If a beneficiary is admitted on the last day of the month, a report showing a charge for hospitalization one day will be submitted. If he is transferred, discharged or dies on the first day of the month, a report showing the condition, but no charge, will be submitted to complete central office records. If the hospitalization is not terminated the report should show that the beneficiary is remaining on the last day of the month for which charges are reported. After seven days absence without leave the beneficiary will automatically be discharged from treatment, specifying discharge for absence without leave.

(B) Charge for such beneficiaries covering authorized treatment in Government hospitals other than those under the direct and exclusive jurisdiction of the Veterans Administration will be at the reciprocal Government hospital rate, viz., \$3.75 per day.

(C) Charge for such beneficiaries covering authorized treatment in civilian contract hospitals will be in accordance with the per diem rate of the contract.] (March 31, 1937.)

7531. [REPORTS ON DISCHARGE FROM HOSPITALIZATION.—All Canadian or British Imperial beneficiaries admitted for authorized treatment to Veterans Administration facilities, will be required to comply with the rules of the facility governing order and discipline of patients. If such patients are discharged for infraction of discipline, the Form 2593, as in the case of Veterans Administration beneficiaries, will show "Disciplinary" - "Discharged for disciplinary reasons," opposite "Disposition;" and the D.P.N.H. Form 100 sent to the Department may be accompanied, as provided in R. & P. 7573, by a statement of the circumstances leading to discontinuance of treatment.] (March 31, 1937.)

7532. [EXAMINATION ON DISCHARGE FROM HOSPITALIZATION.—When a Canadian or British Imperial beneficiary is about to be discharged from hospitalization in a facility under direct and exclusive jurisdiction of the Veterans Administration, he will be given a physical examination, to be reported on D.P.N.H. Form 100, describing in detail his physical condition at that time. This report will be rendered as soon as discharge is effectuated, and will include the date he actually left the hospital. Managers of regional offices and facilities with regional office activities having jurisdiction will acquaint heads of other Government and civil contract hospitals in which such beneficiaries are receiving authorized treatment with this necessity. The report of such examination, as made at such other Government or civil contract hospitals, will be forwarded to the manager of the regional office or facility having jurisdiction. If it is not possible to effectuate this arrangement with heads of other Government or civil contract hospitals, such beneficiaries will be instructed



and supplied transportation to report to the regional office or facility having territorial jurisdiction, to be examined, after discharge from hospitalization (see R. & P. 7560 and 7565). In every case where such beneficiary leaves a hospital without permission, the said report will show the circumstances and particulars of such departure.】 (March 31, 1937.)

#### TREATMENT ALLOWANCES.

7533. DISABILITY MUST BE OF SERVICE ORIGIN TO ENTITLE TO ALLOWANCES.--Ordinary hospital treatment with treatment pay and allowances is authorized only when the condition requiring treatment has been accepted as being related to military service. There are, however, a number of cases in which hospitalization is authorized by the Department for observation purposes before a decision as to service relation has been made. If it is decided that the condition is one of service origin, treatment pay and allowances can be issued by the Department.

7534. 【NO PROMISE OF ALLOWANCES TO BE MADE.--No Canadian or British Imperial beneficiary will be advised by an officer of the Veterans Administration that he will be entitled to pay and allowances upon admission to hospital, unless specially requested so to do by the Department.】 (March 31, 1937.)

#### DENTAL EXAMINATION AND RELIEF

7535. UNAUTHORIZED DENTAL RELIEF.--(A) Expense for dental relief rendered without proper authority, other than that of an emergency nature which is hereinafter defined, will not be borne by the Department:

(B) If relief, other than emergency treatment, is furnished without proper authorization, the person who directed that such relief be furnished or furnished such relief will be held personally responsible for payment of any expense incurred by the United States on account of such relief.

7536. 【DENTAL EXAMINATIONS.--(A) On application by a Canadian or British Imperial beneficiary where expense of any nature will be incurred in connection therewith, dental examination will not be made except upon specific instructions from the Department or medical director.

(B) Reports of dental examinations will be made on Veterans Administration Form 2570, Dental Record Chart and Oral Examination Blank (ignoring notations as to adjunct relief on page 1 thereof, and specifying "Canadian Beneficiary" or "British Imperial Beneficiary," with regiment or unit and regimental number (or rank, if an officer), in place of C-number). Two copies will be forwarded to the Department through the medical director. If the treatment recommended is approved, one copy will be returned by the Department, as authority to proceed with rendition of relief,

(C) Dental X-rays are to be employed only on specific instructions from the Department.】 (March 31, 1937.)

7537. 【DENTAL TREATMENT.--With the exception of cases where the dental defect has been accepted as related to service, the Department will authorize only such dental relief as is considered an essential part of hospital treatment which a Canadian or British Imperial beneficiary is receiving for his pensionable disability.】 (March 31, 1937.)



7538. **EMERGENCY DENTAL TREATMENT.**—When a [hospitalized Canadian or British Imperial beneficiary] presents a dental condition which, if not immediately treated, will adversely affect the service condition for which medical treatment is being given, dental services to the extent of those necessary to relieve an acute condition may be undertaken without authority from the Department. Generally speaking, such relief should be limited to the extraction or the treatment of an aching tooth or other emergency treatment indicated for the relief of oral infection. If emergency treatment is furnished, the report, or a letter of transmittal accompanying the report, must show that an actual emergency existed, that immediate treatment was necessary, and any other facts pertinent to the case. (March 31, 1937.)

7539. **[PROVISION OF DENTURES.**—Only in cases where the dental defect has been service accepted does the Department provide for the upkeep, including the adjustment, repair, or renewal of dental appliances previously supplied. If authorized by the Department in cases of other than service accepted dental defect when following extensive extractions, the masticating areas or the incising areas are sufficiently impaired seriously to affect nutrition, a temporary vulcanite denture may be supplied and may be maintained unless damaged or destroyed through the carelessness or intent of the patient until the gums have sufficiently contracted and hardened, when the denture may be rebased or reset, as required, following which service, repairs and maintenance will not be undertaken by the Department. The patient must not, however, be detained in hospital for the sole purpose of being fitted with dentures.] (March 31, 1937.)

7540. **[DENTAL REPORTS.**—A report showing the expense of dental relief furnished Canadian or British Imperial beneficiaries in facilities of the Veterans Administration will be made immediately upon completion of such treatment, on Veterans Administration Finance Form 1082. See R. & P. 7543.] (March 31, 1937.)

7541. **LAPSE OF AUTHORITY FOR DENTAL TREATMENT.**—Should a [ ] beneficiary whose service was in Dominion (other than Canadian) forces be discharged from hospital before the authorized dental services have been completed, no further action will be taken until a renewal of authority has been obtained from the Department. (March 31, 1937.)

7542. **FAILURE OF BENEFICIARY TO REPORT.**—If a patient fails to report for authorized examination or relief, as the case may be, within two months of the date of the notification forwarded to him, or fails to keep appointments given him without a just reason for either action, the authority will lapse, and a renewal of same must be given by the Department before he may again be considered eligible for a dental examination or relief.

7543. **[FEES FOR DENTAL SERVICES.**—The fees for dental services authorized to be made by designated dentists will be in accordance with those for like services as specified in the current schedule of fees and specifications for dental operations, Veterans Administration. Dental services rendered by dentists employed by the United States on a salary basis will be charged at 50 percent of the like fees in the said schedule.] (March 31, 1937.)

## DEATH CASES

7544. [DEATH OF PERSON RECEIVING TREATMENT.—(A) Upon the death of a Canadian or British Imperial beneficiary while receiving authorized treatment by the Veterans Administration, two copies of the death certificate, accompanied by an appropriate Report, in duplicate, on D.P.N.H. Form 280, will immediately be forwarded by the manager to the medical director. The usual central office copy of Form 2593 will also be transmitted to the budget officer and chief of statistics. One copy of the death certificate and the report on Form 280 will be relayed by the medical director to the Department, and the duplicates of those exhibits will be retained in the medical director's files. Any cost incurred in securing copies of a death certificate will be borne by the Department.

(B) If the name and address of the next of kin are known, and such person resides in the United States, the manager of the facility in which the death occurred, or the manager of the regional office or facility with regional office activities having jurisdiction when the death occurred in another Government or civil contract hospital, will at once notify such person by radiogram or telegram, requesting immediate telegraphic instructions as to what arrangements for interment are desired. If no reply is received within a reasonable time, or a reply is received leaving all arrangements in the hands of the manager, the procedure to be followed will be that applicable where the next of kin does not reside in the United States, viz., the manager concerned will have the body prepared for burial under the terms of his burial contract, and will notify by telegram or radiogram, the Department direct, mailing a copy to the medical director. This radiogram or telegram will incorporate the identifying data specified in R. & P. 7514 (C). See R. & P. 7566 as to telegrams.

(C) The Department will immediately notify, by telegraph, the manager, direct, as to disposition of the body, and will mail a copy of this telegram to the medical director. If the condition of the body will permit, the manager will wait three days from the time he telegraphed, for reply. If no reply is received, or the condition of the body is such that burial is sooner required, the manager may arrange local burial, notifying central office. At facilities having cemeteries on their reservations, such local burial may be made therein, under R. & P. 6336. Also, bodies of deceased pensioners of nations allied with the United States in the World War, who were American citizens at time of death, can be interred in National Cemeteries upon permit of the Secretary of War (Army Regulations, No. 30-1840, June 6, 1923). If the foregoing burials cannot be effected, the manager may purchase a grave site and arrange burial therein, subject to reimbursement by the Department. See R. & P. 7566.] (March 31, 1937.)

7545. TRANSPORTATION OF BODY HOME —When a Canadian [or British Imperial beneficiary,] whose medical treatment has been duly authorized, dies in a hospital or sanatorium in the United States, the reasonable and necessary expenses of transporting the body of such deceased person to his former home (place of residence immediately prior to securing treatment) may be paid, but only when a return of the body to the former home of the deceased is requested by a person entitled to the custody of the body for purposes of interment. The amounts so payable will include the usual charges for transportation of the body and any additional expenses which may be incurred in order to conform to the regulations of the carrier and the health laws of the State



where death occurred, or of the States through which the body will pass, in respect of the preparation of the body for transportation and the character of the container of the body. If under the regulation of the carrier or under the health laws an attendant must accompany the body, the necessary and reasonable expense of such an attendant in going to and returning from the former home of the deceased may be included. [But total expenses incurred will be governed by R. & P. 7546.] (March 31, 1937.)

7546. FUNERAL COSTS-VOUCHERS.--When an ex-member of either the Canadian or British Imperial forces whose hospital treatment has been properly authorized dies in hospital, the Veterans Administration may pay for the funeral costs of such ex-member,--including all charges in connection with the preparation of the body for burial, the cost of transportation with or without escort, the purchase of the grave and the undertaker's charges, - a sum not exceeding \$100 in United States currency.

Subject to this limitation, vouchers covering reimbursement for expenses properly incurred in connection with the funeral of a Canadian or British Imperial beneficiary will be referred to central office. There will be placed on the face of every such voucher a notation showing the number of each transportation request issued for the transportation of the body of the deceased and each transportation, meal and lodging request issued for an attendant or other expenses incurred on account of such burial claim, in order that the amount payable on the voucher may be determined. In such cases claims for reimbursement for services rendered in good faith on Veterans Administration requests will take precedence over claims for reimbursement for other services.

Managers of the Veterans Administration will explain to the next of kin the arrangements made for funerals, so that the large expense often incurred by relatives may be avoided. Then, if the relatives prefer that the funeral be conducted by private undertakers at an increased cost, they will have no right to complain if the charges for services rendered are in excess of the \$100 allowed by the Department.

7547. [PERSONAL EFFECTS OF DECEASED CANADIAN OR BRITISH IMPERIAL PENSIONERS.--Disposition of such effects will be made in accordance with R. & P. 6340-6343. Receipt will be obtained from the consignee to whom the director of finance instructs delivery of the effects, and this receipt forwarded to the director of finance for his information and reference to the medical director for transmittal to the Department. This receipt will be accompanied by the other exhibits provided in R. & P. 7544.] (March 31, 1937.)

#### SURGICAL APPLIANCES

7548. [APPLICATIONS FOR PROSTHETIC APPLIANCES.--(A) On receipt of an application in person or in writing from a Canadian or British Imperial beneficiary who requires a prosthetic appliance or repair of an old appliance, the manager of the field station concerned will communicate with the Department, through the medical director, and will await instructions before taking action, except as hereinafter provided.

(B) Action may be taken by the field station in the following types of cases, provided there is on file in the field station a record, still in force, of the Department's acceptance of the applicant's eligibility for the appliance or repair thereof. Immediate notification of such action will be communicated to the medical director, for transmittal to the Department.

(1) Artificial Legs and Arms.--Minor repairs may be carried out to the value of an amount not to exceed \$20.00.

(2) Surgical Boots.--Repairs occasioned by fair wear and tear may be authorized by the regional office or facility.

(3) Artificial Eyes.--Renewal will be authorized by the Department on receipt of recommendation from central office. Where the case is an emergency one, renewal may be arranged for locally, provided eligibility has been established (See R. & P. 7553).

(4) Minor Orthopedic Appliances.--If the Department has previously authorized the issue or repair of a stock appliance, the regional office or facility may replace or repair the appliance.

(C) The renewal or repair of appliances as detailed in the foregoing will be subject to these conditions:

(1) That the continued use of the appliance is recommended by the chief medical officer or clinical director.

(2) That the need for renewal or repair of an appliance previously issued arises through fair wear and tear, and not through the applicants' negligence or willful damage.

(3) That the minor appliance required is of a type approved as standard under contract to the Veterans Administration.] (March 31, 1937.)

7549. [INQUIRY AS TO DUPLICATE APPARATUS.--When a Canadian or British Imperial beneficiary makes application for a prosthetic appliance and presents an old or used appliance which is partially worn out, he will be asked whether he has a duplicate. If he possesses a duplicate and it is in satisfactory working order, no renewal will be issued without reference to the Department. The old appliance may be repaired for emergency use only in the discretion of the facility.] (March 31, 1937.)

7550. [AUTHORITY TO SUPPLY PROSTHETIC APPLIANCE.--If the regional office or facility has no previous authority on file, the appliance will not be supplied nor repairs made until authority has been received from the Department or central office, Veterans Administration. If central office has on file the previous authority of the Department for the supply or repair of the appliance recommended, the manager of the regional office or facility concerned will be so advised. If there is no record in central office of authority from the Department, application will be made by central office to the Department, and the regional office or facility concerned will be so advised.] (March 31, 1937.)

7551. ORTHOPEDIC LASTS TO BE HELD.--If a Canadian [or British Imperial] beneficiary has been supplied with orthopedic boots or shoes by a manufacturer in the United States, such manufacturer will be instructed by the [manager of the field station concerned] to retain the measurement charts. In any such case it will be unnecessary to request the personal attendance of the beneficiary when renewal is required, unless in the opinion of a medical officer [ ] a change has taken place which necessitates the taking of new measurements or the manufacture of new lasts. (March 31, 1937.)



7552. SPECIAL PROSTHETIC APPLIANCES.--The following are instructions governing the action to be taken in special cases:

(A) When it is necessary to furnish an appliance not covered by the awarded contract, for the correction of a major disability, such as a specially built artificial limb or brace difficult of construction, separate estimates for the article will be obtained by the [manager] in accordance with the recommendation of the [chief] medical officer, and the estimate will be forwarded to central office.

(B) If the Canadian [or British Imperial] beneficiary is wearing an appliance of a special type such as a tilting table, rawhide arm, etc., the [field station] will refer its recommendation to central office for transmission to the Department, and if a renewal or replacement is required advice will be forwarded as to whether such should be manufactured by the Department in its own depot or locally.

(C) In view of the fact that all issues of orthopedic boots and shoes in Canada are manufactured by the Department and lasts and measurement charts are maintained for each individual case, all applications received from [ ] beneficiaries found to be wearing Canadian boots will, if the last issue is satisfactory, be referred to central office, which will communicate with the Department regarding renewal. (March 31, 1937.)

7553. ARTIFICIAL EYES.--As the Department manufactures artificial eyes for practically all of its beneficiaries in Canada and as a model is retained on file, it may be found when a Canadian beneficiary reports for renewal of his artificial eye that his present issue was supplied by the Department. If so, renewal will be made by the Department on receipt of the recommendation from central office. Where a case is an emergency one, renewal may be arranged for locally, provided eligibility has been already established.

7554. BENEFICIARY LIVING NEAR CANADIAN BORDER.--If a Canadian [or British Imperial] beneficiary is living near the Canadian border, it may be more convenient for him to be supplied with a prosthetic appliance or the repair of the same by the Department direct. In such a case the [ ] manager will so advise central office. (March 31, 1937.)

7555. VOUCHERS FOR APPLIANCES TO BE ACCOMPANIED BY BENEFICIARY'S RECEIPT.--A receipt of the claimant for each appliance or repair supplied will be attached to each corresponding voucher, or Finance Form [1082] forwarded to central office by the [field station] and these will be forwarded to the Department, attached to the repayment voucher. See R. & P. 7585. (March 31, 1937.)

#### TRANSPORTATION-GENERAL

7556. [TRANSPORTATION TO BE SUPPLIED BY VETERANS ADMINISTRATION.--The Veterans Administration will provide transportation and the necessary traveling expenses incident thereto for Canadian or British Imperial beneficiaries in connection with travel to and from facilities, and to and from points designated for the making of a physical examination or fitting of a prosthetic appliance. Such transportation and incidental expenses will be charged to the Department at the net cost thereof, subject to the conditions set forth in R. & P. 7557 to 7563.] (March 31, 1937.)

7557. CALLED IN FOR EXAMINATION.—When the Veterans Administration is requested by the Department to examine a Canadian or British Imperial beneficiary for pension purposes, transportation from his home to the place of examination, also transportation for the return journey, either prior to or on completion of examination, may be issued by the manager of the regional office or facility, together with any necessary lodging and meal requests. (March 31, 1937.)

7558. CALLED IN FOR TREATMENT.—When the Veterans Administration is requested by the Department to furnish treatment or hospitalization to a Canadian or British Imperial beneficiary, transportation from his home to the place of treatment, also transportation for the return journey, either prior to or on completion of treatment, may be issued by the manager of the regional office or facility together with any necessary lodging and meal requests. (March 31, 1937.)

7559. CALLED IN FOR REPAIRS TO PROSTHETIC APPLIANCES.—When the Veterans Administration is requested by the Department to arrange for repairs to or renewals of prosthetic appliances issued to a Canadian or British Imperial beneficiary, or when application is received from a Canadian or British Imperial beneficiary for such repairs or renewals and authority has previously been received from the Department, covering the eligibility of the beneficiary for the maintenance and renewal of a prosthetic appliance, transportation from his home to a place where prosthetic appliances are fitted, also transportation for the return journey may be issued by the manager of the regional office or facility together with any necessary lodging and meal requests. (March 31, 1937.)

7560. DISCHARGE FROM HOSPITALIZATION.—When a Canadian or British Imperial beneficiary is discharged from hospitalization transportation will be furnished, if required, to the nearest suitable point where a medical examination can be secured by a medical official of the Veterans Administration. (See R. & P. 7532.)

(A) Destination.—When a Canadian or British Imperial beneficiary, discharged from treatment, is entitled to return transportation, such return transportation will be issued to the point from which transportation was originally furnished or to such other point as will not entail any greater expense for transportation. (March 31, 1937.)

7561. UNAUTHORIZED TRANSPORTATION.—When a person claiming eligibility to treatment as a Canadian or British Imperial beneficiary applies or presents himself for examination or treatment, no requests will be issued or expense incurred on account of such person until authority has been secured from central office. If his eligibility is later established, and the expense is authorized by central office, Voucher for per Diem and Reimbursement of Expenses Incident to Official Travel, Standard Form 1012, covering his expenditures from personal funds for transportation necessary for the journey, will be forwarded to central office. There will also be executed a separate voucher on Standard Form 1034 covering expenditures from his personal funds for subsistence necessary for the journey, which will also be forwarded to central office. The voucher covering transportation will, if found correct, be paid in central office, (an amount not exceeding that which it would have cost had he been ordered to report in the usual manner) and the voucher covering subsistence will be forwarded to the Department for direct settlement. (March 31, 1937.)



7562. [WHEN A BENEFICIARY PRESENTS HIMSELF VOLUNTARILY —If a Canadian (or British Imperial) beneficiary presents himself voluntarily for examination, transportation or subsistence will not be furnished or other expenses incurred until authorized by central office. (See R. & P. 7503).] (March 20, 1939.)

7563. REQUEST FOR AUTHORITY FOR TRANSPORTATION.—In any cases not covered by the foregoing instructions, transportation, lodging and meal requests will not be issued without definite authority from the Department, which may be obtained, by telegram or radio when necessary, through central office.

#### NOTIFICATION OF FACILITY ADMISSIONS, DISCHARGES AND TRANSFERS

7564. ADMISSIONS TO FACILITIES.—Telegrams, collect, addressed to the Department will be forwarded by the manager of a facility under direct and exclusive jurisdiction of the Veterans Administration when a Canadian or British Imperial beneficiary is admitted to such facility; or by the manager of the regional office or facility with regional office activities, having territorial jurisdiction, upon admission of such beneficiary to another Government or civil contract hospital. The telegram will incorporate the identifying data in R. & P. 7514 (C). The name of the manager and location of the facility will be added. If the admission was for a medical emergency, that also will be stated. (March 31, 1937.)

7565. DISCHARGES FROM FACILITIES.—When a Canadian or British Imperial beneficiary is discharged from a Veterans Administration facility after authorized treatment, the Department will be so notified by telegram, collect, without delay. This telegram will be sent by the manager of a facility under direct and exclusive jurisdiction of the Veterans Administration if the discharge is from such facility; or by the manager of the regional office or facility with regional office activities, having territorial jurisdiction, if the discharge is from another Government or civil contract hospital. Arrangements will be made by such managers with heads of Government or civil hospitals to notify the managers promptly upon discharge of such beneficiaries, so that the said telegram may be expeditiously dispatched. The telegram reflecting discharge will contain the identifying data in R. & P. 7514 (C) together with date of discharge; facility from which discharged; the address to which the man is proceeding after discharge; and character of discharge, that is, maximum improvement, against medical advice, absence without leave, disciplinary, etc. (March 31, 1937.)

7566. DEATHS IN HOSPITALS.—When a Canadian or British Imperial beneficiary dies in a Veterans Administration facility, a telegram, collect, will be dispatched by the manager concerned to the Department giving the patient's name, his regiment or unit and regimental number (or rank, if an officer), together with the date and cause of death. (See R. & P. 7544.)

NOTE: The telegrams called for under R. & P. 7564, 7565 and 7566, to be sent in cases of hospital admissions, discharges, and deaths, to the Department, will be sent as night letters, collect, except in an emergency, when day priority messages may be transmitted instead. A telegram or radio message, dispatched perhaps the evening before, will bear a different date when delivered

the following day. Moreover dates on telegrams are often read with difficulty or are even illegible. In the body of the communication should therefore be specified the date of the action taken or occurrence reported, instead of using the words "this date." (March 31, 1937.)

7567. [INTER-FACILITY TRANSFERS.—When a Canadian or British Imperial beneficiary is transferred from one facility to another a letter will be addressed by the manager of the facility making the transfer to the Department showing the identifying data in R. & P. 7514 (C) and the name and address of the facility to which the transfer is being made, together with a statement of the reasons and authority for the move. The manager of the facility to which the patient is admitted, will advise the Department by telegram of the admission as set forth in R. & P. 7564.] (March 31, 1937.)

7568. [FACILITIES TO SEND COPIES OF LETTERS AND TELEGRAMS TO CENTRAL OFFICE.—Copies of all telegrams and letters addressed to the Department will be mailed to the medical director.] (March 31, 1937.)

7569. [REPORTS FROM FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.—All reports reflecting admissions, discharges by death or otherwise, or inter-facility transfers of Canadian or British Imperial beneficiaries from Government facilities other than those under direct and exclusive jurisdiction of the Veterans Administration or from civil contract hospitals, will be handled as heretofore by the managers of the regional offices or facilities with regional office activities having territorial jurisdiction.] (March 31, 1937.)

#### REPORTS-WRITTEN

7570. [FORMS OF REPORTS.—It is of the utmost importance that, in every case where service is rendered a Canadian or British Imperial beneficiary, the report will include the identifying data in R. & P. 7514 (C). Forms for use have been furnished by the Department, but if it is necessary to use plain paper the foregoing identifying data must be placed at the top of each sheet, together with "Report of a Canadian Beneficiary," or "Report of a British Imperial Beneficiary," respectively. These reports are independent of and in addition to Veterans Administration Form 2593, "Record of Domiciliary or Hospital Care," which is to be prepared in triplicate and distributed as provided in R. & P. 6055. The white copy is to be sent to the budget officer and chief of statistics, central office. No copy is to be made for transmission to the Department, either direct or through the medical director.] (March 31, 1937.)

7571. TREATMENT REPORT ON D.P.N.H. FORM 346.—When treatment, either out-patient, home, or hospital, is begun, the date of the beginning of such treatment or the date of entrance into the hospital with the name of the institution to which admitted, will be definitely stated on D.P.N.H. Form 346, which will be prepared promptly in quadruplicate, one copy being retained by the manager who authorized admission, and three copies forwarded to the medical director.

7572. [MONTHLY REPORT OF BENEFICIARIES IN HOSPITALS.—If a Canadian or British Imperial beneficiary is remaining in hospital at the end of a calendar month, a separate report, in quadruplicate, on D.P.N.H. Form 399, will be promptly prepared on his case by the hospital. One copy will be forwarded to the manager who authorized admission, two copies will be sent to the medical director, and one copy forwarded



direct to the Department. This report is essential in the adjustment of maintenance accounts, and in order that the pensioner and his dependents may be paid their monthly allowances without delay, the expeditious preparation and distribution of this report is imperative.] (March 31, 1937.)

7573. [TREATMENT DISCONTINUED REPORT.—The termination of treatment - hospital or out-patient - of a Canadian or British Imperial beneficiary, either through completion of treatment or its discontinuance for other reasons, will be reported promptly to the Department. This notification will be accomplished on D.P.N.H. Form 100, in quadruplicate: the field station concerned will retain one copy and forward three to the medical director, who will retain one copy and forward the original and one copy to the Department. This form may be accompanied, if thought necessary, by a letter giving any detailed information not included in the report, which would be of value to the Department.] (March 31, 1937.)

7574. [COMMUNICATIONS.—Except as provided in R. & P. 7515, and 7564 to 7567 inclusive, all communications, whether telegrams or letters, relative to Canadian or British Imperial beneficiaries, will be addressed to central office, for forwarding to the Department.] (March 31, 1937.)

7575. [PROMPTNESS IN PREPARATION AND FORWARDING OF REPORTS.—Delay in preparing and forwarding the reports and documents provided for in connection with the handling of Canadian or British Imperial beneficiaries will materially affect the pay and allowances, the treatment and comfort of those beneficiaries, and subject the Department and the Veterans Administration to adverse criticism. Accordingly, the utmost expedition will be practiced in fully executing and transmitting such papers.] (March 31, 1937.)

7576. DENTAL REPORTS.—For reports respecting dental treatment, see R. & P. 7540.

#### CHARGES, VOUCHERS, FINANCE REPORTS

7577. [CHARGES (A) EXAMINATIONS.—Charges for out-patient physical and laboratory examinations made at field stations of the Veterans Administration or at other clinics maintained by the United States, will be 50 percent of the maximum fee authorized for the type of examination in the schedule of fees, Veterans Administration. If authorized by the Veterans Administration to be made by a designated physician on a fee basis, such physical examinations are to be charged for at the fee authorized for the required type of examination in the schedule of fees, Veterans Administration.

Charges for dental examinations made at all such field stations by salaried employees will be at 50 percent of the fees allowed for such examination in the schedule of fees, Veterans Administration. If made by a designated dentist such examinations will be charged for at the fee authorized in the schedule of fees and specifications for dental operations, Veterans Administration.

(B) TREATMENTS.—A charge of \$1.00 will be made for each out-patient treatment rendered by physicians employed on a salary basis at field stations, Veterans Administration, or at other clinics maintained by the United States, this charge to cover ordinary medicines, surgical dressings, etc., but not to include expensive medicines such as insulin, serums, etc., treatments authorized to be rendered by designated physicians will be charged for at rates in accordance with fees in the schedule of fees for medical services, Veterans Administration.



A charge of 50 percent of the fees allowed in the schedule of fees and specifications for dental operations, Veterans Administration, will be made for dental treatments rendered at field stations of the Veterans Administration, or at other clinics maintained by the United States, when dental treatment is authorized for rendition by designated dentists, the fees will be in accordance with those listed in the said schedule.

A charge of \$3.75 per day will be made for Canadian or British Imperial beneficiaries while receiving authorized observation or treatment in facilities under direct and exclusive jurisdiction of the Veterans Administration or in other Government hospitals. The per diem charge for authorized hospital treatment of such beneficiaries in civilian contract hospitals will be in accordance with the terms of the current contract made by the said hospital concerned for treatment of beneficiaries of the Veterans Administration. (March 31, 1937.)

7578. ACCOUNTS FOR HOSPITAL TREATMENT.—Form 1082, approved by the Comptroller General, [ ] "Statement of Expenses for Services to Allied Ex-service Men," to cover beneficiaries of the Department who are admitted to United States Government hospitals, will be submitted to the director of finance, central office. Care will be taken to fill in on that form the identifying data, including rank, if an officer. See R. & P. 7530 as to computation of hospital days and R. & P. 4368 as to details regarding preparation of Form 1082. (March 20, 1939.)

7579. ALL REPORTS, CARDS, ETC., TO SHOW DIFFERENTIATION BETWEEN "CANADIAN BENEFICIARY" AND BRITISH IMPERIAL EX-SERVICE MEN.—It is imperative to show on all papers, reports, vouchers, cards, repayment accounts, transportation and other requests, etc., data that will enable central office to differentiate between a "Canadian beneficiary" and a British Imperial ex-service man. Central office in preparing repay vouchers will prepare separate vouchers for each of these two classes of beneficiaries and forward them to the Department. (March 31, 1937.)

7580. NET TRAVELING EXPENSES.—Claims for traveling expenses will be based upon the actual amount paid out by the Veterans Administration, including the cost of traveling expenses for attendants where necessary.

7581. FORMS TO BE USED.—Forms 3266 and 3267, meal and lodging, and special transportation requests, will be issued in sufficient number as required, as in the case of a beneficiary of the Veterans Administration.

7582. VOUCHERS TO BE SUBMITTED.—Bills covering all services rendered Canadian or British Imperial beneficiaries by persons not employed by the United States Government on a salary basis or by firms, corporations, or institutions not controlled by the United States Government, will be forwarded to the regional office or facility which authorized the service where a voucher, Standard Form 1034, or Standard Form 1012 in case of reimbursement of traveling expenses, will be executed, showing the service, date, and the charge for the service. There will be attached necessary bills, affidavits, and supporting papers, including copy of authority from central office, and copy of authority from the regional office or facility, under which the expense was incurred, and the vouchers will be forwarded to central office. Such vouchers shall clearly show that the service was rendered a Canadian or British Imperial beneficiary, and shall not contain a charge for an expense incurred for any other beneficiary. Vouchers covering loss of wages by a Canadian or British Imperial beneficiary shall not include a charge for any other expense, but will show the number



of any requests for meals, lodging, or transportation, issued to the beneficiary or other expenses incurred for the journey during which wages were lost. Vouchers covering reimbursement to a Canadian or British Imperial beneficiary for an expenditure from his personal funds for subsistence or lodging will be stated on voucher, Standard Form 1012. (March 31, 1937.)

7583. USE OF VETERANS ADMINISTRATION FORM 2593.—Form 2593, Record of Domiciliary or Hospital Care, will be prepared to cover admission to and discharge or transfer from a Veterans Administration facility of a Canadian, British Imperial or other allied beneficiary. The preparation and distribution of this form will be in accordance with R. & P. 6055. The green copy will be retained by the facility; the red sent to the regional office or facility which authorized the admission; and the white card will be forwarded to the budget officer and chief of statistics, central office, Washington, D. C. No copy will be prepared for the Department, either for direct transmission or for relay through the medical director. For use of a fourth (white) copy of this form, to be sent to the United States Public Health Service, Washington, D. C., by hospitals of that service, see R. & P. 7594. (March 31, 1937.)

7584. IDENTIFICATION OF VOUCHERS, REPORTS, ETC.—It is important that, in addition to the correct surname, first and middle names of a beneficiary, it be specified whether he is a Canadian or British Imperial pensioner, and the other identifying data in R. & P. 7514 (C) be placed on all vouchers, records, cards, repayment accounts, requests, telegrams, letters or other papers. (March 31, 1937.)

7585. FORM 2529 TO ACCOMPANY VOUCHERS FOR ORTHOPEDIC AND PROSTHETIC APPLIANCES.—Vouchers covering charges for orthopedic and prosthetic appliances furnished Canadian or British Imperial beneficiaries will be accompanied by Form 2529, Prosthetic Appliance Service Card, except as to vouchers covering expense of stump socks. (March 31, 1937.)

7586. PAYMENTS.—All vouchers covering services comprehended under R. & P. 7577 to 7589 will be forwarded to central office for settlement. (March 31, 1937.)

7587. VOUCHERS FOR LOSS OF WAGES.—Vouchers covering claims for loss of wages will also contain a list of all the lodging and meal requests issued to and used by the beneficiary when ordered to report for examination. This will include those issued to and used by him for his return home, as well as those issued to and used by him in order that he may report for examination. (March 31, 1937.)

7588. REPORT OF EXPENSES INCURRED FOR SERVICES RENDERED CANADIAN, BRITISH IMPERIAL, OR OTHER ALLIED BENEFICIARIES — See R. & P. 4368.

7589. RECORDS OF CHARGES, REPAY VOUCHERS, AND RECEIPTS.—Records of charges shown on all vouchers mentioned in the foregoing, except vouchers covering loss of wages or expenditure of personal funds for subsistence, by a Canadian beneficiary, and all reports of expenses incurred for such beneficiaries, will be made of record in central office, and repay vouchers executed to show the expenses, forwarded to the Department. When remittance is received from the Department, official receipt will be forwarded by central office.



DISPOSITION OF RECORDS WHEN CANADIAN BENEFICIARY DIES OR LEAVES THE  
JURISDICTION OF A REGIONAL OFFICE OR FACILITY

7590. DEATH OR RETURN TO CANADA.--When a Canadian beneficiary who has received treatment from the Veterans Administration dies or when a regional office or [ ] facility is notified that the Canadian beneficiary is leaving the territory of that office due to a permanent change of address, and is returning to Canada, all the records on the particular beneficiary will be immediately forwarded to the medical director for disposition, together with a statement showing the reason for such action. (March 31, 1937.)

7591. CHANGE OF ADDRESS TO ANOTHER OFFICE.--When a regional office or [ ] facility is notified that the Canadian beneficiary is leaving or has left the territory of that office due to a permanent change of address located in the territory allocated to another office, all the records on the particular beneficiary will be immediately forwarded to the new office, and the medical director promptly notified of the transfer of the records. (March 31, 1937.)

7592. [ADMISSION OF ALLIED EX-SERVICE PENSIONERS TO FACILITIES.--The regional office or facility with regional office activities which is contacted by a Canadian, British Imperial or other allied ex-service person, will, upon proper authority, admit such beneficiary to a Veterans Administration facility, with a properly executed Form 2557, Admission Card, as authority therefor. The said station will assure itself that a bed is available in the nearest suitable facility before supplying transportation or issuing the authorization for admission.] (March 31, 1937.)

7593. [EX-SERVICE MEN OF THE NEWFOUNDLAND FORCES. (A) In the case of an ex-member of the Newfoundland forces, contact will be made direct with the Department of Public Health and Welfare and War Pensions, St. John's, Newfoundland, since Newfoundland is an independent dominion not connected with the Dominion of Canada.

(B) In sending a telegram to the foregoing address notifying of the facility admission, discharge or death of an ex-service man of the Newfoundland forces, a copy thereof and of the confirmatory letter will be forwarded by the manager of the regional office or facility concerned to the medical director, attention insular and foreign subdivision, central office, Veterans Administration.

(C) The Veterans Administration is authorized to furnish transportation only to ex-members of the Newfoundland forces reporting for medical examinations authorized by central office. No allowances will be paid by the Veterans Administration for meals or loss of time.

(D) Ex-members of the Newfoundland forces are required by the Department of Public Health and Welfare and War Pensions to make claim direct to that agency at St. John's, Newfoundland, for such allowances, and not through field offices of the Veterans Administration.] (March 31, 1937.)

7594. [PROCEDURE FOR PUBLIC HEALTH SERVICE HOSPITALS REGARDING ALLIED BENEFICIARIES.--(A) At the end of each month, the United States Public Health Service will forward to the Veterans Administration, Washington, D. C., a properly certified voucher in duplicate completed to show the names and identifications of pensioners of nations allied with the United States in the World War who were given authorized treatment in the hospitals of the said service. The voucher will incorporate data as to the country of such patient, the services rendered or article furnished, the date or dates on which the service was rendered or article was furnished, the unit price,



and the total charge. This voucher will be checked and approved in the finance service and forwarded to the budget officer for appropriate action, and allotment in arrears will be set up out of Veterans Administration funds upon the books of the Treasury Department in favor of the Public Health Service, to cover the cost of care of these patients, in the same manner that allotments are made in advance as to other Veterans Administration patients.

(B) In computing charges for hospitalization, see R. & P. 7530 (A).

(C) Form 2593 will be executed in quadruplicate for all such admissions. In the space "Class of Beneficiary", will be entered the country under whose flag the man served. The green copy of that form will be retained by such hospital; the red copy forwarded to the regional office or facility of the Veterans Administration which authorized the admission; the white to the budget officer and chief of statistics, central office; and a fourth (white) to the United States Public Health Service, Washington, D. C.] (March 31, 1937.)

7595. FURNISHING PROSTHETIC APPLIANCES TO ITALIAN EX-SERVICE MEN.—The Italian embassy has requested that the Veterans Administration furnish, upon request from its consuls through the embassy in each case, prosthetic appliances to Italian ex-service men resident in this country. Field stations are, therefore, authorized to furnish prosthetic appliances to Italian ex-service men resident in this country, but only upon receipt of authority for this service in each case from the medical director, central office. Vouchers covering prosthetic appliances authorized by central office for Italian ex-service men will be handled in similar manner to those covering treatment and supplies furnished Canadian ex-service men.

PHYSICAL EXAMINATION AND TREATMENT OF CLAIMANTS AND BENEFICIARIES RESIDING IN FOREIGN COUNTRIES AND IN TERRITORIES AND INSULAR POSSESSIONS OF THE UNITED STATES.

7600. CONSULAR OFFICERS TO ACT FOR THE VETERANS ADMINISTRATION IN FOREIGN COUNTRIES.—(A) The Administrator of Veterans Affairs is authorized, at the direction of the President, or with the approval of the head of the Department concerned, to utilize in addition to the facilities of said Veterans Administration, such other Governmental facilities as may be made available to provide for the proper examination, medical care, treatment, hospitalization, dispensary, and convalescent care, necessary and reasonable after care, welfare of, nursing, and such other services as may be necessary for carrying out these purposes, for the performance of which the said Administrator is made responsible by statute, subject to the general directions of the President. (43 Stat. L., 610) In accordance with an agreement entered into between the Secretary of State and the Administrator of Veterans Affairs, consular officers of the United States will perform any of these duties delegated to them in their districts by instructions issued by, or transmitted through the Department of State. They are also charged with the general supervision of Veterans Administration activities within their jurisdiction, and in the absence of special instructions, will promptly submit reports of information received regarding such activities, which may assist the Veterans Administration to discharge efficiently its responsibility to its beneficiaries who reside in foreign countries. (March 20, 1939.)

[(B) The medical director may furnish necessary hospital care including medical treatment to veterans who are citizens of the United States and who are temporarily sojourning or temporarily residing abroad for disabilities due to war service in the armed forces of the United States. The term "temporarily" shall include employees of domestic corporations whose main office is in the United States even though the sojourn or residence abroad may run into years.

(1) For those veterans temporarily located abroad (other than in the Dominion of Canada) the request for treatment will be transmitted by the American Consuls through the Department of State. The medical director upon a favorable determination of eligibility and the practicability of supplying the treatment will inform the Department of State by letter relative to the terms under which the American Consuls may arrange the indicated treatment and the charges therefor.

(2) For those veterans temporarily located in the Dominion of Canada the request for treatment will be transmitted to the medical director by the Medical Officer in Charge, Foreign Relations Section, Department of Pensions and National Health, Ottawa, Canada. Upon a favorable determination of eligibility and practicability of treatment the medical director will authorize the aforementioned Medical Officer in Charge to arrange the indicated treatment. The letter of authority will be specific as to the applicant's eligibility and the condition (injury or disease) which may be treated. Charges for treatment rendered in the Dominion of Canada will be in accordance with the fees specified in R. & P. 7577 (B), that is, the same fees as are charged by the Veterans Administration for services rendered pensioners of nations allied with the United States in the World War.

(3) The American Consuls involved and the Medical Officer in Charge, Foreign Relations Section, Department of Pensions and National Health, Ottawa, Canada, must be satisfied that the veteran seeking treatment is a citizen of the United States before any treatment authorized by the medical director may be supplied.] (February 15, 1941.)



#### 7601. REQUESTS FOR PHYSICAL EXAMINATIONS; INFORMATION TO CONSULAR OFFICERS.

(A) Requests upon the Department of State to arrange through a consular officer the physical examination of applicants for Government life insurance and total disability insurance or reinstatement of such insurance (the costs of which examinations are at the expense of the applicant) are made directly by the director of insurance or by the director of finance. Requests upon the Department of State to arrange physical examinations for other purposes are made by the medical director.

(B) Such requests upon the Department of State contain specific information as to the service desired. These requests should specify: The type of physical examination desired (whether general or specialistic, or both); the amount of fees to be allowed; in what circumstances transportation and incidental expenses can be allowed a claimant or the examining physician; how reimbursement is to be made when transportation is allowable; character of receipts to be submitted in support of vouchers for reimbursement, etc. (March 20, 1939.)

7602. PREFERENCES IN TYPES OF MEDICAL OFFICERS TO MAKE EXAMINATIONS.--Medical officers of the United States Army, Navy, or Public Health Service, when their services are available, will be preferably requested by consular officers to make physical examinations of Veterans Administration beneficiaries in foreign countries. Where such officers are not available, American physicians, if qualified and available, will be next preferred. When these preferences can not be exercised, the consul will make other arrangements for examinations.

7603. PLACE OF EXAMINATION.--Beneficiaries in foreign countries will be ordered, for physical examinations, to present themselves in the city where the consul resides, unless a beneficiary's condition be such that examination in his home is indicated, or that travel of the beneficiary is impossible, or unless the consul is convinced of the ability and integrity of a physician in the veteran's home community. Officers of the United States Public Health Service detailed to United States consulates to make examinations of intending immigrants will not be called upon to make physical examinations of Veterans Administration beneficiaries which necessitate travel from their official stations. Beneficiaries of the Veterans Administration who are to be examined by such officers will be ordered to be present at the examining rooms in use by such officers; and where examinations of beneficiaries are necessary at their homes in cities where such officers are stationed, consuls will be expected to arrange the time for such examinations so that there will be the least interference with the regular duties of such medical officers. Officers of the United States Public Health Service, who are stationed at places other than those where the medical examination of intending immigrants is conducted, are authorized, on request of consular officers, to travel to such places in the vicinity of their stations as may be necessary in making examination of Veterans Administration beneficiaries at such time as their regular duties permit.

7604. REIMBURSEMENT OF EXPENSES OF EXAMINATIONS.--Reimbursement of actual and necessary subsistence expenses incurred in travel of an officer of the United States Public Health Service to accomplish physical examination of a beneficiary, under the circumstances discussed in R. & P. 7603, will be made by the consular officer requesting the service at \$6 per diem in lieu of subsistence. (October 15, 1932.)

7605. AUTHORITY FOR SERVICES WHICH THE UNITED STATES PUBLIC HEALTH SERVICE IS NOT EQUIPPED TO RENDER.--Whenever expenses are necessary for medical services--such as X-ray or laboratory examinations--which the officer of the United States Public



Health Service is not equipped to render, such officer will be instructed to advise the consular officer of the need, so that authority may be secured to make expenditures for such services from Veterans Administration funds, since appropriations of the United States Public Health Service are not available therefor.

7606. REPORTS FROM MEDICAL OFFICERS.--Medical officers will be required to execute and deliver to the consular office such reports, forms, etc., as are required by the Veterans Administration.

7607. FEES FOR MEDICAL SERVICES NOT PAYABLE TO MEDICAL OFFICERS OF THE UNITED STATES ARMY, NAVY, OR PUBLIC HEALTH SERVICE.--Salaried officers of the United States Army, Navy, or Public Health Service are not entitled to fees for making examinations of beneficiaries of the Veterans Administration.

7608. FEES FOR PHYSICAL EXAMINATIONS.--In an emergency the consul concerned may contract to pay a fee for physical examination which is in excess of the Veterans Administration schedule of fees, including fee for such authorized hospital observation as is determined necessary but will furnish a complete statement detailing the necessity for the excess fee and the nature of the emergency. However, the fee will not be in excess of prevailing fees in the community for similar service. The lower cost of living in most countries other than the United States, and the fact that the fees specified in the official schedule of fees, Veterans Administration, are maximum and can be lowered, make it a matter of expectation to the Veterans Administration that consular officers can and should obtain physical examinations of American beneficiaries at prices lower than those set forth in the official schedule of fees, Veterans Administration, whenever possible. (March 20, 1939.)

7609. INTERPRETATION OF X-RAY FILM TO BE RECORDED.--An interpretation of any exposed X-ray film or plate will be recorded in the examination report on the applicable case. After the interpretation is so recorded, the picture or plate or film will be forwarded to the Veterans Administration, Washington, D. C., where the interpretation will be verified. (March 20, 1939.)

7610. PHYSICAL EXAMINATION BY BOARDS.--Special instructions will be given in each case to consular officers for physical examination by boards of physicians.

7611. PHYSICAL EXAMINATIONS OF EX-MEMBERS OF THE MILITARY OR NAVAL FORCES OF THE UNITED STATES WHO RESIDE IN CANADA.--These are to be made by the Department of Pensions and National Health, Ottawa, Canada, upon authorization of the Veterans Administration. Consular officers of the United States stationed in Canada have no jurisdiction in these examinations. (March 20, 1939.)

7612. MONTHLY ACCOUNTS OF EXPENDITURES.--(A) In submitting their monthly accounts covering expenditures made on behalf of beneficiaries of the Veterans Administration, consular officers will use care in preparing vouchers and other attached papers. All bills will include dates of physical examinations including hospital observation, if authorized, or investigations. As payments of accounts have to be computed in accordance with exchange rates, it is important that the exchange rates used by the consular officers in paying the vouchers be shown on their accounts. Reimbursement made by consular officers to veterans for travel and subsistence expenses incurred in reporting for physical examination, will be based upon itemized receipts.

(B) Receipts will be required for the following classes of expenditures: Extra-fare trains; hire of special conveyances such as livery, boat, automobile, or local taxicab fare in excess of \$1; lodging; meals obtained continuously at hotels, res-



taurants, or boarding houses, and paid for in a lump sum (receipts for meals paid for when eaten are not required) (see R. & P. R-6104); miscellaneous emergency expenses when the amount involved exceeds \$1. All receipts will show the dates of the charges.

(C) In requesting a beneficiary to report for examination the consular officer will instruct him to furnish a completely itemized statement of his traveling expenses, accompanied by receipts. Receipts and statements will be attached to consular accounts. (March 20, 1939.)

7613. PREPARATION OF VOUCHERS.--To obtain uniformity and to avoid suspensions and delays in auditing accounts of consular officers covering disbursements for beneficiaries of the Veterans Administration, it is required that all such disbursements be made by the consular officer in charge, and that supporting vouchers and receipts be forwarded in triplicate with his monthly accounts. Each set of vouchers must show that payment has been received from the consular officer, and must bear the full name and compensation number of the beneficiary, as well as references to any special instructions under which the consular officer acted. One case only will be covered in each set of vouchers. (March 20, 1939.)

[7616 canceled February 15, 1941.]

BURIAL OF BENEFICIARIES WHOSE ONLY RELATIVE RESIDES IN A FOREIGN COUNTRY OR IN AN INSULAR OR TERRITORIAL POSSESSION OF THE UNITED STATES - See R. & P. Supply.

DEPORTATION OF PATIENTS.- See R. & P. 6281.

7619. TRANSPORTATION OF ALASKAN APPLICANTS TO THE CONTINENTAL LIMITS OF THE UNITED STATES.--In cases where prolonged hospitalization is indicated, travel is not interdicted by reason of the applicant's condition, and it would be more economical to hospitalize an eligible Alaskan applicant in a Veterans Administration facility located in the continental United States than to pay for hospitalization in a contract hospital in Alaska, transportation to the United States can be authorized by the office having jurisdiction, viz., Veterans Administration, Seattle, Washington. (March 20, 1939.)

REPORT OF DENTAL EXAMINATION IN TERRITORIES AND INSULAR POSSESSIONS. -- See R. & P. 6630.

# MEDICAL

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## APPENDIX

### SCHEDULE OF FEES

The fees listed are the maximum fees allowed [except upon approval of the Surgeon General or his designate. Fees will not be authorized in excess of those charged the general public for similar services in the locality where rendered. If it is impossible to secure services for the fees listed, or if there is a need for services not listed and not analogous to those listed, recommendation with comment will be submitted to the Surgeon General by mail, radio, or telegram, dependent upon circumstances. Whenever possible, such submissions will be in advance of the authorization of services. In actual emergencies, services may be tentatively authorized at equitable fees pending approval of the Surgeon General or his designate.] (January 12, 1946.)

6000.	EXAMINATIONS	Maximum amount allowed
1.	Bronchoscopy.....	\$ 30.00
2.	Bronchoscopy and biopsy.....	40.00
3.	Dermatological examination.....	5.00
4.	Electrocardiogram with interpretation.....	10.00
5.	Encephalography, air injection by spinal route for diagnostic purposes.....	40.00
6.	Esophagoscopy.....	30.00
7.	Examination of ears, nose and throat (separately or together).....	5.00
8.	Special ear examination, including audiometric test, with chart.....	10.00
9.	Special ear examination to include either caloric or Barany test, or both, with report.....	10.00
10.	Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings - the latter by chart in all cases of optic atrophy).....	5.00
11.	Examination of eyes with refraction, if mydriatic is used (to in- clude either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings - the latter by chart in all cases of optic atrophy).....	7.50
12.	Combined examination of eyes, ears, nose and throat, with re- fraction (with or without mydriatic).....	7.50
13.	Gastrosocopy.....	30.00
14.	Genitourinary examination without cystoscopy.....	5.00
15.	Genitourinary examination with cystoscopy.....	10.00
16.	Genitourinary examination with cystoscopy and ureteral catheterization.....	20.00
17.	Gynecological examination.....	5.00



	Maximum amount allowed
18. Complete examination of heart, including electrocardiography.....	\$ 15.00
19. Physical examination of heart or lungs, or both.....	5.00
20. Neurological examination (complete).....	5.00
21. Neuropsychiatric examination (complete).....	7.50
22. Routine office examination, including treatment.....	2.00
23. Orthopedic examination.....	5.00
24. Physical examination to determine need for hospitalization.....	3.00
25. Complete physical examination.....	5.00
26. Proctoscopy or sigmoidoscopy.....	5.00
27. General surgical examination.....	5.00
28. Thoracoscopy.....	30.00
29. Ventriculography, air injection through skull for diagnostic purposes.....	75.00

## CLINICAL LABORATORY EXAMINATIONS

### BACTERIOLOGICAL EXAMINATIONS:

30. Cultural examination for fungi.....	5.00
31. Microscopic examination for fungi.....	1.00
32. Pneumococcus typing.....	3.00
33. Pus or exudate (smear).....	1.00
34. Pus or exudate, cultural examination, including classification of organism.....	5.00
35. T. Pallidum (dark field).....	2.00
36. Throat culture, including classification of organism.....	5.00
37. Throat smear.....	1.00

### BLOOD:

38. Agglutination test for typhoid, paratyphoid, dysentery, or undulant fever.....	2.00
39. Bleeding time.....	1.00
40. Blood calcium.....	3.00
41. Blood chlorides.....	3.00
42. Blood culture, including classification of organism in positive culture.....	5.00
43. Blood platelet count.....	1.50
44. Blood smear for malaria.....	1.00
45. Blood typing (grouping).....	2.00
46. Carbon dioxide combining power of blood plasma (Van Slyke).....	3.00
47. Chemical examination of blood, complete, including creatinin, dextrose, urea nitrogen (or non-protein N) and uric acid.....	7.50
48. Cholesterol.....	3.00
49. Coagulation time.....	1.00
50. Complement fixation test for gonococcus infection.....	4.00
51. Complement fixation test for syphilis.....	4.00
52. Complement fixation test for tuberculosis.....	4.00
53. Creatinin.....	3.00
54. Dextrose.....	3.00
55. Total erythrocyte count.....	1.50

	Maximum amount allowed
56. Fragility test for erythrocytes.....	\$ 3.00
57. Hemoglobin estimation.....	1.00
58. Hydrogen ion concentration.....	3.00
59. Differential leucocyte count.....	1.50
60. Total leucocyte count.....	1.50
61. Complete blood count, including total erythrocyte count, hemoglobin estimation, differential leucocyte count and total leucocyte count..	5.00
62. Non-protein nitrogen.....	3.00
63. Occult blood.....	1.00
64. Blood phosphorous.....	2.00
65. Precipitation test for syphilis.....	2.00
66. Reticulocyte count.....	2.00
67. Sedimentation rate.....	2.00
68. Estimation of sugar tolerance.....	5.00
69. Urea nitrogen.....	3.00
70. Uric acid.....	3.00
71. Van den Bergh blood test for icterus.....	2.00
72. Volume index.....	2.00

#### FECES:

73. Cultural examination of feces for causative microorganism (including classification of bacterium).....	5.00
74. Fat in feces.....	1.00
75. Parasites and ova.....	2.00

#### PATHOLOGICAL EXAMINATIONS:

76. Autopsy, complete, with report (including histological examinations)	35.00
77. Tissue examination, with report.....	5.00

#### SKIN TESTS:

78. Protein sensitization tests (series), including allergens, for the purpose of establishing causative factor.....	10.00
79. Tuberculin.....	2.00

#### SPINAL FLUID:

80. Examination of spinal fluid for causative organism (smear).....	2.00
81. Cell count.....	1.50
82. Colloidal gold reaction.....	3.00
83. Complement fixation test for syphilis.....	4.00
84. Cultural examination of spinal fluid, including classification of causative microorganism.....	5.00
85. Globulin test.....	1.00
86. Complete examination of spinal fluid, including complement fixation test, colloidal gold reaction, globulin test, and cell count.....	7.50
87. Precipitation test for syphilis.....	2.00



	Maximum amount allowed
<b>SPUTUM:</b>	
88. Tubercle bacillus (plain smear).....	\$ 2.00
89. Tubercle bacillus (concentration method).....	3.00

<b>STOMACH CONTENTS:</b>	
90. Examination of duodenal content for pancreatic ferments.....	5.00
91. Examination of gastric content for acidity, by histamine.....	3.00
92. Examination of gastric content for pepsin.....	3.00
93. Routine, chemical (including test meal and withdrawal of stomach content).....	5.00

<b>URINE:</b>	
94. Chemical examination, routine.....	1.00
95. Chemical and microscopical examination.....	1.50
96. Chlorides.....	3.00
97. Creatinin.....	3.00
98. Cultural examination, including classification of microorganism.....	3.00
99. Hydrogen ion concentration.....	3.00
100. Mosenthal test.....	3.00
101. Total nitrogen.....	3.00
102. Renal function test, (including phenolsulphonephthalein).....	3.00
103. Tubercle bacilli.....	2.00
104. Urea nitrogen.....	3.00
105. Uric acid.....	3.00
106. Urobilin.....	1.00

<b>MISCELLANEOUS EXAMINATIONS:</b>	
107. Animal inoculation for diagnosis, with report of autopsy.....	5.00
108. Preparation of autogenous vaccine.....	5.00
109. Determination of basal metabolic rate.....	5.00

#### SIMPLE FRACTURES

110. Carpal bone, one.....	15.00
111. Carpal bones, each additional.....	5.00
112. Clavicle.....	40.00
113. Coccyx.....	15.00
114. Femur.....	75.00
115. Femur, when suture, plating or nailing is necessary.....	100.00
116. Fibula or tibia, or both (including Potts fracture).....	40.00
117. Fibula or tibia, or both (including Pott's fracture) when suture or plating is necessary.....	75.00
118. Finger, one.....	15.00
119. Fingers, each additional.....	5.00
120. Humerus.....	40.00
121. Humerus, when suture or plating is necessary.....	75.00

	Maximum amount allowed
122. Malar bone.....	\$ 25.00
123. Maxilla inferior (wiring if necessary).....	75.00
124. Maxilla superior (wiring if necessary).....	75.00
125. Metacarpal bone, one.....	15.00
126. Metacarpal bones, each additional.....	5.00
127. Metatarsal bone, one.....	15.00
128. Metatarsal bones, each additional.....	5.00
129. Nasal bones.....	20.00
130. Patalla.....	40.00
131. Patella, when suture or plating is necessary.....	75.00
132. Pelvis.....	75.00
133. Pelvis, when suture or plating is necessary.....	125.00
134. Radius or ulna, or both (including Colles' fracture).....	40.00
135. Radius or ulna, or both (including Colles' fracture), when suture or plating is necessary.....	75.00
136. Rib, one.....	15.00
137. Ribs, each additional.....	5.00
138. Sacrum.....	50.00
139. Scapula.....	40.00
140. Skull.....	85.00
141. Sternum.....	40.00
142. Tarsal bone, one.....	15.00
143. Tarsal bones, each additional.....	5.00
144. Toe, one.....	15.00
145. Toes, each additional.....	5.00
146. Vertebra, one or more.....	100.00
Note:--These amounts include 15 days' routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.	

#### COMPOUND FRACTURES

147. Carpal bone, one.....	20.00
148. Carpal bones, each additional.....	10.00
149. Clavicle.....	50.00
150. Coccyx.....	40.00
151. Femur.....	100.00
152. Femur, when suture, plating or nailing is necessary.....	125.00
153. Fibula.....	50.00
154. Fibula, when suture or plating is necessary.....	75.00
155. Finger, one.....	25.00
156. Fingers, each additional.....	10.00
157. Humerus.....	60.00
158. Humerus when suture or plating is necessary.....	100.00
159. Malar bone.....	40.00
160. Maxilla inferior (wiring if necessary).....	100.00



	Maximum amount allowed
161. Metacarpal bone, one.....	\$ 20.00
162. Metacarpal bones, each additional.....	10.00
163. Metatarsal bone, one.....	20.00
164. Metatarsal bones, each additional.....	10.00
165. Nasal bones.....	30.00
166. Patella.....	60.00
167. Patella, when suture or plating is necessary.....	75.00
168. Pelvis.....	125.00
169. Pelvis, when suture or plating is necessary.....	150.00
170. Radius or ulna, or both.....	60.00
171. Radius or ulna, or both, when suture or plating is necessary.....	100.00
172. Rib, one.....	25.00
173. Ribs, each additional.....	10.00
174. Sacrum.....	75.00
175. Scapula.....	50.00
176. Skull, vault.....	100.00
177. Sternum.....	50.00
178. Tarsal bone, one.....	20.00
179. Tarsal bones, each additional.....	10.00
180. Tibia.....	60.00
181. Tibia, when suture or plating is necessary.....	100.00
182. Tibia and fibula.....	75.00
183. Tibia and fibula, when suture or plating is necessary.....	125.00
184. Toe, one.....	20.00
185. Toes, each additional.....	10.00
186. Vertebra, one or more.....	125.00

Note.--These amounts include 15 days routine after care,  
exclusive of hospital charges, anesthetic, and X-ray fees.

### DISLOCATIONS

187. Carpal bone, one.....	15.00
188. Carpal bones, each additional.....	5.00
189. Clavicle.....	35.00
190. Elbow.....	35.00
191. Finger, one.....	10.00
192. Fingers, each additional.....	5.00
193. Hip.....	60.00
194. Knee.....	50.00
195. Maxilla inferior.....	15.00
196. Metacarpal bone, one.....	15.00
197. Metacarpal bones, each additional.....	5.00
198. Metatarsal bone, one.....	15.00
199. Metatarsal bones, each additional.....	5.00
200. Nasal bones.....	10.00
201. Patella.....	40.00

	Maximum amount allowed
202. Pelvis .....	\$ 75.00
203. Rib .....	15.00
204. Shoulder .....	40.00
205. Shoulder, recurrent or habitual.....	25.00
206. Tarsal bone, one.....	15.00
207. Tarsal bones, each additional.....	5.00
208. Thumb.....	15.00
209. Toe, one.....	10.00
210. Toes, each additional.....	5.00
211. Vertebra, one or more.....	75.00

Note.—These amounts include 15 days routine after care,  
exclusive of hospital charges, anesthetic, and X-ray fees.

### AMPUTATIONS

212. Upper arm.....	75.00
213. Forearm.....	75.00
214. Finger, one.....	25.00
215. Fingers, each additional.....	10.00
216. Foot.....	75.00
217. Hand.....	75.00
218. Leg.....	75.00
219. Thigh.....	100.00
220. Toe.....	25.00
221. Toes, each additional.....	10.00

Note.—These amounts include 15 days routine after care,  
exclusive of hospital charges, anesthetic, and X-ray fees.

### ABSCESS, INCISION AND DRAINAGE

222. Brain abscess.....	150.00
223. Carbuncle, excision of.....	20.00
224. Cellulitis, incision and drainage.....	25.00
225. Deep abscess (including Ishiorectal).....	20.00
(Fee does not include usual 15 days after care. Additional charge may be allowed for after care.)	
226. Empyema, incision and drainage, including rib resection.....	100.00
227. Liver abscess.....	150.00
228. Oral abscess (not to include dental or peridental).....	15.00
229. Prostatic abscess, incision and drainage.....	50.00
230. Superficial abscess.....	5.00
(Fee does not include usual 15 days after care. Additional charge may be allowed for after care.)	
231. Subphrenic abscess.....	100.00

Note.—These amounts include 15 days routine after care,  
exclusive of hospital charges, anesthetic, and X-ray fees,  
except as to items numbered 225 and 230.



OPERATIONS		Maximum amount allowed
232.	Abdominal fixation for prolapse of rectum.....	\$ 100.00
233.	Adenectomy, cervical, inguinal, etc. (minor).....	20.00
234.	Adenectomy, cervical, inguinal, etc. (radical).....	75.00
235.	Anal fissure, operation for.....	40.00
236.	Anastomosis, intestinal.....	150.00
237.	Anastomosis, uretero-intestinal.....	150.00
238.	Ankle joint, excision of.....	75.00
239.	Apicolysis.....	100.00
240.	Appendectomy.....	75.00
241.	Arthroplasty, major joint.....	125.00
242.	Biopsy.....	10.00
243.	Bone graft (long bones).....	150.00
244.	Bone plate, removal of.....	35.00
245.	Breast, resection of (simple).....	75.00
246.	Breast, resection of (radical).....	100.00
247.	Carcinoma of lower lip, excision of.....	50.00
248.	Carcinoma of rectum, excision of.....	150.00
249.	Carcinoma of tongue, excision of.....	75.00
250.	Cardiospasm, dilatation for.....	25.00
251.	Cartilage of condyle of femur, removal of.....	50.00
252.	Semilunar cartilage, removal from joint.....	50.00
253.	Cervix, amputation of.....	50.00
254.	Cholecystectomy.....	100.00
255.	Cholecystotomy.....	100.00
256.	Choledochotomy.....	100.00
257.	Chordotomy.....	125.00
258.	Circumcision.....	15.00
259.	Claw foot, operation for.....	50.00
260.	Coccyx, excision of.....	40.00
261.	Colostomy.....	100.00
262.	Colporrhaphy.....	75.00
263.	Cystotomy, suprapubic.....	75.00
264.	Dupuytren's contraction, operation for.....	100.00
265.	Elbow joint, excision of.....	75.00
266.	Epididymectomy.....	40.00
267.	Esophagus, dilatation of by means of Bougies or sounds.....	25.00
268.	Femoral artery, ligation of.....	75.00
269.	Fecal fistula, abdominal, operation for.....	75.00
270.	Fistula, rectovaginal, operation for.....	75.00
271.	Fistula, urethral, operation for.....	25.00
272.	Fistula, vesicovaginal, operation for.....	75.00
273.	Fistula-in-ano, operation for.....	50.00
274.	Fulguration of tumor of bladder, trachea, or esophagus (minor).....	25.00
275.	Fulguration of tumor, superficial.....	10.00

	Maximum amount allowed
276. Gasserian ganglion, excision of.....	\$ 150.00
277. Gastrectomy (partial).....	150.00
278. Gastroenterostomy.....	150.00
279. Hallux valgus, operation for.....	25.00
280. Hallux valgus, bilateral, operation for.....	40.00
281. Hammer toe, operation for.....	25.00
282. Heart, operations on.....	150.00
283. Hemorrhoidectomy.....	40.00
284. Herniotomy, diaphragmatic.....	100.00
285. Herniotomy, ventral, inguinal, or femoral.....	75.00
286. Herniotomy, ventral, inguinal, or femoral (bilateral).....	100.00
287. Hip joint, excision of.....	125.00
288. Hydrocele, aspiration of.....	5.00
289. Hydrocele, operation for.....	40.00
290. Hysterectomy, abdominal or vaginal (including removal of adnexa, if indicated).....	100.00
291. Ingrown toenail, excision of.....	15.00
292. Intestinal obstruction, operation for.....	100.00
293. Knee joint, excision of.....	100.00
294. Laminectomy.....	125.00
295. Laparotomy, exploratory.....	75.00
296. Laparotomy and drainage, general peritonitis.....	125.00
297. Litholapaxy.....	75.00
298. Lobectomy.....	150.00
299. Meckel's diverticulum, excision of.....	100.00
300. Nephrectomy or Nephrotomy.....	150.00
301. Nephropexy.....	150.00
302. Nerve, suture of.....	100.00
303. Supraorbital nerve, injection of.....	10.00
304. Neuroma, resection of.....	75.00
305. Oleothrax.....	25.00
306. Orchidectomy.....	50.00
307. Osteomyelitis, operation for.....	50.00
308. Ovariectomy.....	100.00
309. Papilloma of bladder, operation for.....	75.00
310. Paracentesis of abdomen.....	15.00
311. Paracentesis of pericardium.....	20.00
312. Paracentesis of thorax.....	15.00
313. Perineum, repair of.....	75.00
314. Phrenic nerve operation.....	50.00
315. Pneumolysis, extrapleural or intrapleural.....	100.00
316. Pneumonectomy.....	200.00
317. Pneumonotomy, cautery.....	100.00
318. Pneumoperitoneum, first induction.....	25.00
319. Pneumoperitoneum, refills.....	10.00



	Maximum amount allowed
320. Artificial pneumothorax, first induction.....	\$ 25.00
321. Artificial pneumothorax, refills.....	10.00
322. Prostatectomy, perineal.....	125.00
323. Prostatectomy, suprapubic (one or two stages).....	150.00
324. Prostatic resection, transurethral.....	100.00
325. Cisterna puncture, including local anesthetic and obtaining fluid..	50.00
326. Lumbar puncture, including local anesthetic and obtaining fluid.....	10.00
327. Pyelotomy, with removal of calculus.....	150.00
328. Pyloroplasty.....	100.00
329. Salpingectomy.....	100.00
330. Scaleniotomy.....	50.00
331. Sequestrum, removal of (deep).....	75.00
332. Sequestrum, removal of (superficial).....	25.00
333. Shoulder joint, excision of.....	75.00
334. Skull, decompression of.....	100.00
335. Fixation of spine, operation for (Albee or Hibb's).....	150.00
336. Splenectomy.....	100.00
337. Stricture of rectum, operation for.....	40.00
338. Sympathectomy, cervical.....	175.00
339. Sympathectomy, periarterial.....	75.00
340. Tenorrhaphy, one.....	40.00
341. Tenorrhaphy, each additional.....	10.00
342. Tenotomy.....	25.00
343. Thoracotomy.....	50.00
344. Thoracoplasty, each stage.....	100.00
345. Thyroid artery, ligation of.....	50.00
346. Thyroidectomy.....	100.00
347. Torticollis, operation for.....	75.00
348. Tumor, abdominal, removal of.....	125.00
349. Tumor of brain, operation for.....	200.00
350. Tumor, gastrointestinal tract, resection of, including intestinal anastomosis.....	150.00
351. Tumor or cyst, deep, removal of.....	25.00
352. Tumor or cyst, superficial, removal of.....	10.00
353. Ulcer, gastric or duodenal, operation for.....	125.00
354. Ureteral stone, removal of.....	125.00
355. Urethral stricture, dilatation of.....	5.00
356. Urethrotomy, external.....	40.00
357. Urethrotomy, internal.....	25.00
358. Prolapsus uteri, operation for, including perineal repair.....	100.00
359. Uterine displacement, abdominal, operation for.....	100.00
360. Uterus, dilatation and curettage of.....	50.00
361. Varicocele, operation for.....	40.00
362. Varicose veins, injection treatment, each injection.....	5.00

	Maximum amount allowed
363. Varicose veins, one leg, operation for.....	\$ 60.00
364. Varicose veins, both legs, operation for.....	100.00
365. Venesection.....	15.00
366. Whitehead's operation.....	75.00
367. Wrist joint, excision of.....	75.00

Note.--(a) These amounts include 15 days post-operative care, exclusive of hospital charges, anesthetic, and X-ray fees. (b) When the appendix is removed incident to a laparotomy for another condition, a maximum additional allowance of \$25.00 may be made for the appendectomy.

#### SURGICAL CARE OF TRAUMATIC WOUNDS

368. Incised.....	15.00
369. Lacerated.....	20.00
370. Punctured.....	15.00

Note.--These amounts include 15 days routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.

#### ANESTHESIA

371. Avertin anesthesia.....	10.00
372. General Anesthetic	
(a) By visiting physician.....	10.00
(b) By interne or nurse.....	5.00
(In case of gas anesthesia, an additional allowance of \$5.00 may be authorized for the gas used.)	
373. Local anesthesia - No fee will be allowed for local anesthesia in cases which require a local anesthetic for examination, treatment, or surgical operation.	
374. Rectal anesthesia.....	10.00
375. Spinal anesthesia, including anesthetic.....	20.00

#### EYE OPERATIONS

376. Cataract, needling operation for.....	50.00
377. Cataract, operation for.....	100.00
378. Chalazion, operation for.....	10.00
379. Corneal ulcer, cauterization of.....	10.00
380. Extensive peripheral corneal ulcer, cauterization of.....	20.00
381. Ectropion, operation for.....	50.00
382. Entropion, operation for.....	50.00
383. Enucleation of eye.....	75.00
384. Foreign body, removal from conjunctiva (dissection).....	15.00
385. Foreign body, removal from conjunctiva (magnet).....	10.00
386. Foreign body, removal from cornea (dissection).....	25.00



	Maximum amount allowed
387. Foreign body, removal from cornea (magnet).....	\$ 20.00
388. Foreign body, removal from eyeball (deep).....	25.00
389. Grattage of lids for trachoma.....	5.00
390. Hordeolum, operation for.....	5.00
391. Iridectomy.....	75.00
392. Lacrymal duct, dilatation of.....	10.00
393. Lacrymal sac, excision of.....	50.00
394. Pterygium, operation for.....	40.00
395. Ptosis, skin and tarsal resection, operation for.....	75.00
396. Strabismus, operation for.....	80.00
<u>Note</u> :--These amounts include 15 days routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.	

#### EAR OPERATIONS

397. Mastoid, acute, operation for.....	100.00
398. Mastoid, radical, operation for.....	125.00
399. Ossiculectomy.....	75.00
400. Paracentesis.....	20.00
401. Polypus, removal of.....	25.00
402. Lateral sinus, drainage of.....	125.00
<u>Note</u> :--These amounts include 15 days routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.	

#### NOSE AND THROAT OPERATIONS

403. Adenoidectomy.....	20.00
404. Antrum, intranasal, drainage of.....	20.00
405. Antrum, radical, operation for.....	100.00
406. Cleft palate, operation for.....	100.00
407. Harelip, operation for.....	75.00
408. Intubation.....	25.00
409. Laryngectomy.....	150.00
410. Larynx, cauterization of.....	10.00
411. Tumor of larynx, removal of.....	100.00
412. Nasal polypus, removal of.....	25.00
413. Nasal septum, submucous resection of.....	50.00
414. Pharyngeal abscess, operation for.....	20.00
415. Accessory nasal sinuses, irrigation of.....	10.00
416. Ethmoid sinus, radical, operation for.....	75.00
417. Frontal sinus, intranasal, drainage of.....	50.00
418. Frontal sinus radical, operation for.....	100.00
419. Sphenoid sinus, drainage of.....	50.00
420. Tonsillar abscess, operation for.....	20.00
421. Tonsillectomy.....	35.00

	Maximum amount allowed
422. Tonsillectomy and adenoidectomy.....	\$ 45.00
423. Tracheotomy.....	50.00
424. Turbinate bone, galvano-cauterization of.....	20.00
425. Turbinectomy.....	25.00

Note:—These amounts include 15 days routine after care,  
exclusive of hospital charges, anesthetic, and X-ray fees.

### X-RAY WITH INTERPRETATION

426. Abdomen, flat plate.....	7.50
427. Ankle joint, anteroposterior and lateral views.....	5.00
428. Arm, humerus, anteroposterior and lateral views.....	5.00
429. Bladder, with injection, anteroposterior view.....	10.00
430. Chest, for pulmonary, cardiac or rib fracture diagnosis, plain.....	7.50
431. Chest, for pulmonary, cardiac or rib fracture diagnosis, stereoscopic.....	10.00
432. Clavicle, anteroposterior view.....	5.00
433. Elbow, anteroposterior and lateral views.....	5.00
434. Fluoroscopy, when required, without film.....	5.00
435. Foot, anteroposterior and lateral views.....	5.00
436. Forearm, radius and ulna, anteroposterior and lateral views.....	5.00
437. Foreign body in eye, location of (the fragment charted in three planes and its dimensions ascertained by the method of Sweet or equivalent).....	25.00
438. Gall bladder, Graham technic, including cost of dye.....	15.00
439. Gastrointestinal tract, complete X-ray study including fluoroscopy.....	25.00
440. Hand, anteroposterior and lateral views.....	5.00
441. Hip joint, anteroposterior view, plain.....	7.50
442. Hip joint, anteroposterior view, stereoscopic.....	10.00
443. Intestine, barium clysma, 14 by 17 films for position and outline..	10.00
444. Jaw, upper and lower.....	5.00
445. Kidneys, right and left for comparison.....	7.50
446. Knee joint, anteroposterior and lateral views.....	5.00
447. Leg, tibia and fibula, anteroposterior and lateral views.....	5.00
448. Lipiodol injection for bronchiectasis, etc., including roentgenograms.....	20.00
449. Pelvis, anteroposterior view, plain.....	7.50
450. Pelvis, anteroposterior view, stereoscopic.....	10.00
451. Pyelography, using uroselectan or similar preparation (including cost of drug).....	15.00
452. Pyelography, retrograde.....	25.00
453. Scapula.....	5.00
454. Shoulder joint, anteroposterior view, plain.....	5.00
455. Shoulder joint, anteroposterior view, stereoscopic.....	10.00



	Maximum amount allowed
456. Sinuses, frontal and ethmoid, anteroposterior and lateral views.....	\$ 10.00
457. Sinuses, mastoid, right and left sides for comparison.....	10.00
458. Sinuses, maxillary, anteroposterior and lateral views.....	10.00
459. Sinuses, frontal, ethmoid and maxillary, anteroposterior and lateral views.....	15.00
460. Skull, anteroposterior and lateral views, plain.....	10.00
461. Skull, anteroposterior and lateral views, stereoscopic.....	15.00
462. Spine, cervical, anteroposterior and lateral views.....	7.50
463. Spine, dorsal, anteroposterior and lateral views.....	10.00
464. Spine, lumbosacral, with coccyx, anteroposterior and lateral views.....	10.00
465. Spine, entire (Items 462, 463 and 464).....	22.50
466. Stomach, barium or bismuth meal, 14 by 17 film; after in- gestion, four 8 by 10 films for detection of duodenal cap; total of five films, including fluoroscopy.....	20.00
467. Teeth, single (up to and including 7 films) each.....	1.00
468. Teeth, series (7 films to and including full mouth) series.....	7.00
469. Thigh, femur, anteroposterior and lateral views.....	7.50
470. Wrist, anteroposterior and lateral views.....	5.00

#### INTERPRETATION OF ROENTGENOGRAMS

471. Bones and joints, plain anteroposterior and lateral views.....	3.00
472. Chest for pulmonary diagnosis, plain or stereoscopic.....	3.00
473. Gastrointestinal series.....	3.00
474. Genitourinary tract.....	3.00
475. Kidney films.....	3.00
476. Skull, following ventriculography or encephalography.....	3.00

#### X-RAY AND RADIUM THERAPY

477. Radium therapy, per milligram hour..... (Minimum fee \$5.00; maximum expenditure allowed not to exceed \$100.00; where additional treatments are necessary, special authority must be obtained from Central Office)	0.05
478. X-ray therapy, deep, per treatment..... (Maximum expenditure allowed not to exceed \$100.00; where additional treatments are necessary, special authority must be obtained from Central Office)	10.00-25.00
479. X-ray therapy, superficial.....	5.00

#### MISCELLANEOUS

480. Ambulance service - trip within city limits - day or night rate, per trip.....	5.00
481. Ambulance service - trip requiring travel beyond city limits - rate per mile beyond city limits, one way only; this in addi- tion to rate per trip within city limits.....	0.50

	Maximum amount allowed
482. Blood transfusion.....	\$ 35.00
483. Amount allowed for blood furnished, when not donated, per 100 c.c.	5.00
484. Colonic irrigation.....	3.00
485. Non-surgical drainage of the gall bladder.....	2.00
486. Electrocardiograms, interpretation of.....	3.00
487. Hypodermoclysis.....	10.00
488. Making impressions for arch support, per foot.....	1.50
489. Injection of alcohol, trigeminal nerve.....	35.00
490. Intravenous injection, exclusive of cost of drug.....	3.00
491. Services of graduate registered nurse, per day.....	6.00
(a) An additional allowance of \$1.50 per day may be authorized for board and room	
492. Occupational therapy, per diem - contract.....	0.25
493. Operating room, use of.....	10.00
(This item is to be considered only in instances where the per diem rate is not applicable.)	
494. Per diem allowance for bed in private room.....	5.00
(when condition of patient makes necessary)	
495. Per diem allowance for bed in semi-private room.....	4.00
(when condition of patient makes necessary)	
496. Per diem allowance for bed in ward.....	3.00
497. Physiotherapy, per treatment.....	2.00
(No combination of physiotherapy treatments given a patient at any one time shall exceed \$3.00 per day)	
498. Application of plaster case, chest (including material).....	10.00
499. Application of plaster cast, thighs and hips (including material).....	25.00
500. Application of plaster cast, thigh and leg (including material).....	5.00
501. Application of plaster cast, torso (including material).....	15.00
502. Application of plaster cast, torso and hips (including material).....	20.00
503. Application of plaster cast, torso, entire body, (chest to feet, including material).....	40.00
504. Application of plaster cast for disease or injury of vertebrae including material).....	15.00
505. Protein desensitization treatment, including allergen.....	2.00
506. Spinal medication, any type, as with meningococcus serum, salvarsan, etc., (exclusive of cost of drug or biological).....	15.00
507. Surgical assistant's fee, except for unusual condition.....	10.00

#### VISITS

508. Visit to home or hospital.....	3.00
509. Night visit away from office.....	5.00



	Maximum amount allowed
510. Office visit.....	\$ 2.00
511. Visit out of city or town for examination or treatment. In addition to the fee for examination or treatment there may be authorized \$3.00 per hour for actual time consumed in travel plus actual expenses of transportation.	
512. Consultation — only by authority from central office, except in emergency.....	25.00
In addition \$3.00 per hour for actual time consumed in travel when consultant is required to make visit beyond city limits. This in addition to actual expense of travel.] (July 1, 1939.)	

[6001 to 6014 canceled July 1, 1939.]

### SCHEDULE OF FEES -- DENTAL

[The fees listed are the fees allowed (except upon approval of the Branch Medical Director or his designate. Fees will not be authorized in excess of those charged the general public for similar service in the locality where rendered. If there is a need for services not listed, recommendation with comment will be submitted to the Branch Medical Director by mail, radio or telegram, dependent upon circumstances.)

6015.

1.	Examination and Execution of Form 10-2570 (See Note 1).....	\$ 4.00
2.	Radiographs:	
	Single (up to and including 7 films) first film.....	2.00
	each additional.....	1.00
	Series (8 films to and including full mouth).....	10.00
	Intra-Oral, Occlusal View, Maxillary or Mandibular, each.....	2.00
	Superior or Inferior Maxillary, Extra Oral, One Film.....	5.00
	Superior or Inferior Maxillary, Extra Oral, Two Films.....	7.50
3.	Professional visits to bedside, (See Note 2).....	6.00
4.	Special Consultation Fee, necessity to be shown.....	10.00
5.	Prophylaxis Treatment (to include scaling and polishing of teeth)...	4.00
6.	Pyorrhea Treatment.....	4.00
7.	Microscopic Examination for Vincents Infection.....	2.00
8.	Vincents Infections:	
	First Treatment (See Note 3).....	5.00
	Subsequent Treatments, limited to four, each treatment.....	2.00
9.	Emergency Treatment, Palliative.....	2.00
10.	Extractions: (See Note 4)	
	Single with local anesthesia.....	3.00
	Impacted Teeth (See Note 5).....	(10.00-30.00)
11.	Post Operative Treatment Not Covered by Flat Fee-	
	On Supplemental Authorization With Necessity Shown.....	2.00
12.	Anesthetics:	
	General.....	5.00
13.	Fractures:	
	Simple:	
	Maxilla, Superior, Reduction, Fixation, Post Operative Care.....	75.00
	Maxilla, Inferior, Reduction, Fixation, Post Operative Care.....	75.00
	Compound and/or Comminuted:	
	Maxilla, Superior, Reduction, Fixation, Post Operative Care.....	100.00
	Maxilla, Inferior, Reduction, Fixation, Post Operative Care.....	100.00
14.	Dislocation:	
	Maxilla, Inferior.....	10.00



15.	Extirpation of Pulp, Treatment, Filling of Root Canal	
	Radiograph (see Note 6) For Single Rooted Tooth.....	9.00
16.	Amalgam Filling:	
	Cavities Involving One-Tooth Surface.....	3.00
	Cavities Involving Two Tooth Surfaces.....	5.00
	Cavities Involving Three or More Tooth Surfaces.....	8.00
17.	Gold Fillings or Inlays:	
	Anterior Teeth:	
	One Surface Cavities.....	8.00
	Mesio - Or Disto-Incisal Cavities.....	12.00
	Mesio - Inciso-Distal Cavities.....	15.00
	Posterior Teeth:	
	Cavities Involving Two-Tooth Surfaces.....	14.00
	Cavities Involving Three or More Tooth Surfaces.....	18.00
18.	Silicate Cement Fillings.....	4.00
19.	Crowns:	
	Acrylic or Porcelain Jacket.....	30.00
	Gold:	
	One or Two Piece, With Swaged Cusps:	
	Molar.....	13.00
	Bicuspid.....	10.00
	Cuspid or Incisor.....	10.00
	With Heavy Cast Cusps or All Cast:	
	Molar.....	18.00
	Biscuspid.....	15.00
	Cuspid or Incisor.....	15.00
	Three-Quarter, Any Tooth.....	16.00
20.	Bridge Work:	
	Abutments (See crowns and inlays)	
	Pontics:	
	Cast Gold, Posterior (Sanitary).....	15.00
	Gold and Porcelain:	
	Steele's Facing Type.....	15.00
	Tru-Pontic Type.....	18.00
	Removable: One Piece Casting, Gold or Chrome Cobalt Alloy	
	Clasp Attachment (all types).....	15.00
	Pontic (Including Tooth).....	15.00
21.	Recementing:	
	Inlay.....	2.00
	Crown.....	2.00
	Bridge.....	4.00
22.	Repairs, Crowns and Bridges:	
	Replace Broken Pin Facing with Bryant Repairs.....	7.00
	Replace Broken Pin Facing with Steele's Repairs.....	7.00
	Replace Broken Steele's Facing Where Post Backing is Intact.....	3.00
	Replace Broken Steele's Facing where Post on Backing is	
	Broken.....	7.00

23. Dentures:

Full Upper or Lower:

Acrylic..... 50.00

Partial Upper or Lower without Clasps:

Acrylic..... 50.00

Partial Upper or Lower with Two Gold Chrome Cobalt Alloy

Clasps:

Acrylic..... 65.00

Partial Lower With Gold or Chrome Cobalt Alloy

Lingual Bar and Two Clasps:

Acrylic..... 75.00

Partial Upper With Gold or Chrome Cobalt Alloy Palatal

Bar and Two Clasps:

Acrylic..... 75.00

Clasps, Additional, Gold or Chrome Cobalt Alloy..... 7.50

Denture Adjustment (see Note 7)..... 2.00

24. Repairs, Dentures Acrylic:

Broken Denture, Repairing (no teeth involved)..... 6.00

Broken Denture, Repairing and Replacing Broken Teeth.

Each Tooth, Additional..... 1.50

Replacing Broken Teeth on Denture Only:

First Tooth..... 4.00

Each Additional Tooth..... 1.50

Adding Teeth to Partial Denture to Replace Extracted

Natural Teeth:

First Tooth..... 10.00

Each Additional Tooth..... 1.50

Replacing Clasp on Denture Clasp Intact..... 8.00

Replacing Broken Clasp on Denture With New Clasp..... 12.00

25. Duplication, Upper or Lower, Full or Partial..... 25.00

- NOTES: (1) Sufficient scaling of teeth to insure complete and accurate examination will be performed.
- (2) Participating Dentist may elect payment on hourly basis or for fees allowed for services rendered. Additional fees for transportation will not be allowed.
- (3) Prophylaxis should follow.
- (4) Maximum fees allowed for extractions, fractures and dislocations will include local anesthetic and routine post-operative care.
- (5) Fee for impacted teeth within allowable range determined authorizing officer according to severity of impaction.
- (6) Radiograph showing completed root canal therapy must be submitted.
- (7) Fee for denture adjustment may be authorized when indicated but not to the participating dentist constructing the replacement. (May 25, 1946.)





## MEDICAL

### APPOINTMENTS

6030. [REFUSAL OF] TREATMENT BY UNNECESSARILY BREAKING APPOINTMENTS.--[A patient under outpatient medical or dental treatment who breaks an appointment, without a reasonable excuse for such action, will be informed that a repetition of the offense will be deemed to be a refusal of Government treatment. If such patient breaks a second appointment, without at least 24 hours notice, or a reasonable excuse, it will be deemed that he] has refused Government treatment. Thereafter no further treatment will be furnished until [he] has made a specific formal application therefor and has satisfactorily evinced a willingness to accept Government treatment and to cooperate with the Government agency providing the treatment, by keeping his appointments, or by giving at least 24 hours notice where an appointment must necessarily be broken. Where an appointment is broken without notice and satisfactory reasons are shown for the breaking of the appointment, and it is also satisfactorily shown that circumstances attending the breaking of the appointment were such that notice could not be given, the [patient] will not be deemed to have refused treatment. Nothing in this paragraph will be construed to prevent a [patient] from receiving the benefit of treatment for an emergency condition that may arise during the time when he has been determined to be "Not entitled to treatment" as a result of refusal. (January 1, 1948.)

### EMERGENCY HOSPITALIZATION

6035. GENERAL AUTHORITY FOR EMERGENCY HOSPITAL TREATMENT.--[(A)] All potential beneficiaries having prima facie entitlement therefor, who are in need of emergency hospital treatment, may be provided therewith, and such emergency hospital treatment may, if necessary, be continued until a definite decision is reached as to the eligibility of the applicant for medical treatment. This authority for emergency hospitalization carries authority to supply Government transportation and necessary meals and lodging en route to the facility designated for the emergency admission.

[(B)] Emergency hospitalization may also be provided applicants who have not completed a prescribed period of exclusion from hospitalization, imposed because of infraction of facility discipline; but Government transportation (and necessary meals and lodging en route) will not be supplied these applicants, unless they execute affidavit that they are unable to defray the expense of travel to the facility designated.

[(C)] The provisions of (B) hereof are also applicable to a member of a State Soldiers Home, on whose behalf the said home is receiving Federal aid payments, who is discharged therefrom for disciplinary reasons.] (January 1, 1948.)



## MEDICAL TREATMENT IN FOREIGN COUNTRIES

6036. **[ELIGIBILITY FOR MEDICAL TREATMENT IN FOREIGN COUNTRIES.--]** No person shall be entitled to receive domiciliary, medical or hospital care, including treatment, who resides outside of the continental limits of the United States or its territories or possessions, except that the **[chief]** medical director may authorize hospitalization, including medical treatment, determined necessary for diseases or injuries adjudicated as incurred in or aggravated by active military or naval service in a period of war, for applicants temporarily sojourning or temporarily residing in a foreign country, who are citizens of the United States. **[(Sec. 4, Public No. 866, 76th Congress.)]** (January 1, 1948.)

## HOSPITALIZATION AND DOMICILIARY CARE

6045. **PERSONS ENTITLED TO HOSPITAL OBSERVATION AND PHYSICAL EXAMINATION.--**Hospitalization for observation and physical (including mental) examination may be effected when requested by an authorized official, or when found necessary in physical examination of the following persons:

(A) Claimants or beneficiaries of the VA, for purposes of disability compensation, pension, emergency officers retirement pay, medical feasibility for vocational training under Public Law 16, 78th Congress, and Government insurance.

(B) Claimants or beneficiaries referred from a facility to a diagnostic center for study to determine the clinical identity of an obscure disorder, or for advice as to treatment.

(C) Employees of the VA when necessary to determine their mental or physical fitness to perform official duties. (October 8, 1945.)

(D) Claimants or beneficiaries of other Federal agencies: (1) Bureau of War Risk Litigation, Department of Justice - plaintiffs in Government insurance suits. (2) United States Civil Service Commission - annuitants or applicants for retirement annuity, and such examinations of prospective appointees as may be requested. (3) **[Bureau of Employees Compensation]** - to determine identity, severity or persistence of disability. (4) Railroad Retirement Board - applicants for annuity under Public No. 162, 75th Congress. (5) Other Federal agencies.

(E) Pensioners of nations allied with the United States in World War I **[and World War II,]** upon authorization from accredited officials of the respective governments. (January 1, 1948.)

6046. PERSONS ENTITLED TO HOSPITAL TREATMENT OR DOMICILIARY CARE. -- Hospital treatment or domiciliary care may be provided:

(A) Subject to the eligibility provisions of R&P R-6047 and R-6048, for: (October 8, 1945.)

(1) Persons discharged [or released from active military or naval service under other than dishonorable conditions].

(2) Persons retired from [active military or naval service] including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had served honorably during a war period (Public No. 198, 76th Congress, as amended by Public Law 365, 77th Congress). (January 1, 1948.)

(3) Persons retired from the Army of the United States under Public No. 18, 76th Congress, as amended by Public Law 262, 77th Congress. (October 8, 1945.)

(4) Persons retired from the Army, Navy, Marine Corps or Coast Guard, Regular Establishment, not having had war service who elect to receive [ ] compensation under laws administered by the VA in lieu of retirement pay (Public Law 314, 78th Congress). (January 1, 1948.)

(B) Not subject to the eligibility provisions of R&P R-6047 and R-6048, for: (October 8, 1945.)

(1) Persons in active service with the United States Army (Public No. 177 and Public No. 852, 76th Congress), or United States Navy or Marine Corps (Public No. 675, 70th Congress), when duly referred with authorization therefor, may be supplied hospital treatment. Emergency treatment may be rendered such persons upon their own application, when absent from their commands, provided that covering formal authorization be procured as promptly as possible after the emergency treatment is begun. [ ]

(2) Hospital treatment may be provided, upon authorization, for beneficiaries of the [Public Health Service, Bureau of Employees Compensation and other Federal agencies.]

(3) Pensioners of nations allied with the United States in World War I [and World War II,] may be supplied hospital treatment when duly authorized. [ ] (January 1, 1948.)

(C) Emergency hospital treatment may be provided for:



(1) Persons having no prima facie eligibility therefor, as a humanitarian service.

(2) Persons admitted because of presumed discharge or retirement from the armed forces, but subsequently found to be ineligible as such. (October 8, 1945.)

(3) Employees (not potentially eligible as ex-members of the armed forces) and members of their families, when residing on reservations of field stations of the VA, and when they cannot feasibly obtain emergency treatment from private facilities. [ ]

(D) Persons comprehended under the provisions of (B) and (C) may be supplied hospitalization after the needs of emergency applicants under (A) are fully met. [Charges at prescribed rates will be made for the services rendered.] (January 1, 1948.)

6047. ELIGIBILITY FOR HOSPITAL TREATMENT OR DOMICILIARY CARE OF PERSONS DISCHARGED, [RELEASED] OR RETIRED FROM [ACTIVE] MILITARY OR NAVAL SERVICE.--Within the limits of VA facilities, hospital treatment or domiciliary care may be furnished the following applicants in the specified order of preference:

(A) Hospital treatment for: (1) Persons who served [in the active military or naval forces] during the period of World War I as defined in paragraphs I and IV, Veterans Regulation No. 10, as amended; or in any war prior to the Spanish-American War; or during the Spanish-American War, Philippine Insurrection, or Boxer Rebellion from April 21, 1898, to July 4, 1902 (or to July 15, 1903, if the service was in Moro Province), or on or after December 7, 1941, and before [twelve o'clock noon December 31, 1946,] including those who had active duty as a member of the [Womens Army Auxiliary Corps,] Women's Army Corps, Women's Reserve of the Navy and Marine Corps and the Women's Reserve of the Coast Guard - when discharged under other than dishonorable conditions from a period of war service, and when suffering from an injury or disease incurred or aggravated in line of duty in that period of active military or naval service, and for which they are medically determined to be in need of hospital treatment.

(2) [Persons retired from active military or naval service] including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had honorable service in a period of war, as defined in (A) (1) hereof, and are medically determined to need hospital treatment for an injury or disease that was incurred in line of duty in active military or naval service (Public No. 198, 76th Congress; Public Law 365, 77th Congress). (January 1, 1948.)

(3) Persons included in paragraph III, Part I, Veterans Regulation No. 1 (a), who are suffering from injuries or diseases incurred in line of duty, for which they are receiving disability compensation, and for which they are in need of hospital treatment. (October 8, 1945.)

(4) Persons included in Public Law 300, 78th Congress, who, on or after December 7, 1941, and [before twelve o'clock noon December 31, 1946, suffered] an injury or disease in line of duty for which they are receiving disability compensation [ ] and for which they are in need of hospital treatment.

(B) Hospital treatment for: (1) [Persons who were discharged or released under other than dishonorable conditions from active military or naval service for disability incurred or aggravated in line of duty or who are in receipt of compensation for service-connected or service-aggravated disability, when suffering from injuries or diseases incurred or aggravated in line of duty in such active] service, and for which they are medically determined to be in need of hospital treatment. Cadets and midshipmen discharged from the academies at West Point, [New London,] and Annapolis who meet these requirements as to character of discharge or receipt of [compensation] are eligible under this subparagraph, regardless of the requirement as to active military or naval service. (See also section 10, Public Law 144, 78th Congress.)

(a) For applicants not in receipt of [compensation for service-connected or service-aggravated] disability, the official records of the Army or Navy, respectively, relative to findings of line of duty for its purposes, will be accepted in determining eligibility for hospital treatment under this subparagraph (B); except that where the official records of the Army or Navy show a finding of disability not incurred [or aggravated] in line of duty and evidence is submitted to the VA which permits of a different finding, the decision of the Army or Navy will not be binding upon the VA, which will be free to make its own determination of line of duty incurrence [or aggravation] upon the evidence so submitted. It will be incumbent upon the applicant to present such controverting evidence and, until he so acts and a determination favorable to him is made by the VA, the finding of the Army or Navy will control and hospitalization will not be authorized. Such controverting evidence, when received from an applicant, will be referred to the adjudicating agency which would have jurisdiction if the applicant were filing claim for pension or disability compensation, and the determination of such agency as to line of duty, which is promptly to be communicated to the manager of the [field station] receiving the application for hospitalization, will govern his disapproval or approval of admission, other eligibility requirements having been met. Where the official records of the Army or Navy show that the disability on account of which a veteran was discharged or [released] from his peacetime service under other than dishonorable conditions was incurred [or aggravated] in line of duty, such showing will be accepted for the purpose of determining his eligibility for hospitalization, notwithstanding the fact that the VA has made a determination in connection with a claim for monetary benefits that the disability was incurred [or aggravated] not in line



of duty. See also Public No. 648, 75th Congress, defining line of duty, whether on active duty or authorized leave, relative to applicants whose only military or naval service was in a period other than wartime.

[ ]

(b) When the applicant is in receipt of [compensation] for a service-connected [or service-aggravated] disability, inquiry will not be made as to the character of discharge from service. [ ]

(c) In those exceptional cases where the official records of the Army or Navy show [discharge or release under other than dishonorable conditions] because of expiration of period of enlistment or any other reason save disability, but also show a disability incurred [or aggravated] in line of duty during the said enlistment; and the disability so recorded is considered in medical judgment to be or to have been of such character, duration, and degree as to have justified a discharge for disability had the period of enlistment not expired or other reason for discharge [or release] been given, the [chief] medical director, upon consideration of a clear, full statement of the circumstances submitted to him is authorized to approve admission of the applicant for hospital treatment, provided other eligibility requirements are met. A typical case of this kind would be one where the applicant was under treatment for the said disability recorded during his service at the time discharge was given for reason other than disability.

(2) Persons retired from the Army of the United States under Public No. 18, 76th Congress, as amended by Public Law 262, 77th Congress, who had service only in a period other than wartime and who are suffering from a disease or injury incurred [or aggravated] in line of duty which is medically determined to require hospital treatment.

(3) Persons defined in R&P R-6046 (A) (4) who are in need of hospital treatment for that disease or injury for which they are receiving disability [compensation].

(4) Persons included in Public Law 300, 78th Congress, who on or after August 27, 1940, and prior to December 7, 1941, suffered an injury or disease in line of duty for which they are receiving disability compensation [ ] and for which they are in need of hospital treatment.

(C) Hospital care for: (1) [Persons who were discharged or released from active military or naval service under other than dishonorable conditions for disability incurred or aggravated in line of duty, or who are in receipt of compensation for service-connected or service-aggravated disability, when suffering from nonservice-connected diseases or injuries requiring hospitalization. See also subparagraphs (B) (1), (a), (b), (c) which apply here, and to (2) following.] (January 1, 1948.)  
(Paragraph 6047 continued)

(1) "Any disability, disease or defect" will comprehend any acute, subacute or chronic disease (of a general medical, tuberculous or neuropsychiatric type) or any acute, subacute or chronic surgical condition, susceptible of cure or decided improvement by hospital care; or any condition which, not susceptible of cure or decided improvement by hospital care, indicates need for domiciliary care. Domiciliary care, as the term implies, is the provision of a home, with such incidental medical care as is needed. To be entitled to domiciliary care the applicant must consistently have a disability, disease or injury which, chronic in type and not susceptible of cure or decided improvement by hospitalization, is producing disablement of such degree and probable persistency as will incapacitate from earning a living for a prospective period. Defects such as constitutional psychopathic inferiority or mental deficiency, without superimposed psychosis or psychoneurosis, will not indicate hospital treatment, but will entitle to domiciliary care, other requirements being met, if such defects are producing material social and industrial inadaptability. (March 25, 1942.)

(2) "Unable to defray expenses of hospitalization or domiciliary care (including transportation to and from a VA facility)." The affidavit of the applicant on VA Form 10-P-10 that he is unable to defray the expenses of hospitalization or domiciliary care (including transportation to and from a [VA facility] will constitute sufficient warrant to furnish hospitalization or domiciliary care (including Government transportation to cover transportation to the facility).] But, having in mind the penal provisions of the law governing the making of false sworn statements, managers will report to central office any and all cases in which they suspect false statements as to inability to defray the expenses of hospitalization or domiciliary care (including transportation). Such reports will include all the facts, with comment and recommendation. (January 1, 1948.)

(C) Persons applying for hospital treatment under subparagraph (C) or (D) of R&P R-6047 and who are potentially entitled to other hospital treatment or to reimbursement for the costs of hospital treatment because of membership in a union, fraternal organization, or group hospitalization plan under commercial insurance companies' policies covering illness or injury; or as beneficiaries of a State Industrial Commission or Employees Compensation Commission, etc., will not be furnished hospital treatment without charge therefor to the extent of such reimbursement. Action will be taken to effect collection from the persons, companies, organizations or agencies (other than Federal) in the amounts determined payable under the terms of the applicable insurance policy, plan, agreement or other undertaking. (April 22, 1946.)



6050. UTILIZATION OF FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--For the purposes of Veterans Regulation No. 10 (b), Paragraph XIX, defining "Veterans Administration facilities" and section 1500, Public 346, 78th Congress, granting authority to the Administrator of Veterans Affairs "To enter into contracts or agreements with private or public agencies or persons for necessary service, including personal services, as he may deem practicable," the following provisions will govern in authorizing admissions to facilities other than those under the direct and exclusive jurisdiction of the VA:

(A) Hospitalization will not be authorized in Government facilities other than those over which the VA has direct and exclusive jurisdiction until agreement covering such service has been approved. Such agreements, will not be entered into until careful consideration has been given to the best interests of both the Government and beneficiaries. (April 22, 1946.)

(B) (1) Private facilities will not be used for hospitalization of beneficiaries except when facilities under direct and exclusive jurisdiction of the VA or other Government facilities under agreement are not feasibly available, or when the physical or mental condition of beneficiaries will not allow of their transfer thereto from a private, State, or municipal hospital. Male beneficiaries in need of treatment of an emergent condition (a) arising from a service-connected disorder; [or] (b) which in medical judgment requires treatment to prevent interruption of training authorized under Public Law 16, 78th Congress, [ ] may be authorized hospitalization in any private, State, or municipal hospital, preferably one under contract. In such medically emergent cases authorization of admission to a private, State, or municipal hospital may be given, subject to the conditions stipulated in (2) hereof and, when so given, will be authority for payment of vouchers covering the cost of such hospitalization. Hospitalization of male beneficiaries in a private, State, or municipal hospital under contract may also be authorized for treatment of (a) a nonemergent service-connected condition; (b) that condition determined as incurred or aggravated in line of duty in active Federal service and for which the applicant was discharged under conditions other than dishonorable, provided service connection for such disability has not been denied by the VA and (c) a nonemergent nonservice-connected condition which in medical judgment requires treatment to prevent interruption of training authorized under Public Law 16, 78th Congress, provided facilities under direct and exclusive jurisdiction of the VA or other Government facilities under agreement are not feasibly available.

(2) The chief medical officer or his designate, of the regional office or center having jurisdiction of the territory in which the concerned private, State, or municipal hospital, contract or noncontract, is located, when

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(2) Domiciliary care for persons enumerated in (C) (1), when suffering from a permanent disability or tuberculous or neuropsychiatric ailment and who are incapacitated from earning a living and who have no adequate means of support. If a member is discharged on his own request or at the expiration of seven days following an authorized pass or leave of absence, it will be presumed he no longer regards himself as incapacitated from earning a living. Under such circumstances he will not be furnished hospitalization or domiciliary care until the expiration of one month from the date of such discharge, except when requiring readmission in a medical emergency. (June 19, 1947.)

(3) [ ] Retired personnel of the classes comprehended by (B) (2) may be supplied hospital treatment in a hospital or center under the direct and exclusive jurisdiction of the VA, if beds are available, and such applicants agree to pay the per diem rate to cover subsistence, which is set by the Administrator of Veterans Affairs.

(D) Hospital treatment or domiciliary care for: (1) [Persons who served in the active military or naval forces, including those who had active duty as a member of the women's army auxiliary corps,] regardless of length of service, during a period of war as defined in subparagraph (A) (1), who were (a) discharged [or released from active duty] under other than dishonorable conditions; (b) who swear that they are unable to defray the expense of hospitalization or domiciliary care (including the expense of transportation to and from a VA [facility]); and (c) who are suffering from a disability, disease or defect which, being susceptible of cure or decided improvement, indicates need for hospital care, or which, being essentially chronic in type and not susceptible of cure, or decided improvement by hospital care, is producing disablement of such degree and of such probable persistency as will incapacitate from earning a living for a prospective period, and thereby indicates need for domiciliary care. Except for applicants presenting emergent conditions, consideration in admissions under this subparagraph may be given to the length or character of service. [ ]

(2) [Persons retired from active military or naval service] including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had honorable service in a period of war, as defined in (A) (1) hereof, and who meet the other eligibility requirements of (1) hereof (Public No. 198, 76th Congress; Public Law 365, 77th Congress). (January 1, 1948.)

(3) If a member is discharged on his own request or at the expiration of seven days following an authorized pass or leave of absence, it will be presumed he no longer regards himself as incapacitated from earning



a living. Under such circumstances he will not be furnished hospitalization or domiciliary care until the expiration of one month from the date of such discharge except when requiring readmission in a medical emergency. (June 19, 1947.)

6048. DEFINITIONS APPLICABLE IN DETERMINING ELIGIBILITY FOR HOSPITAL TREATMENT OR DOMICILIARY CARE.

(A) Under subparagraph (C) (2) of R&P R-6047:

(1) A "permanent disability" will be taken to mean such impairment of mind or body as may reasonably be expected to continue throughout the remainder of the applicant's life, or any condition listed in R&P R-1086. A permanent disability must be such as would materially interfere with the following of any substantially gainful occupation. This must be for medical determination, which shall not be influenced by the applicant's inability - due to industrial conditions, lack of personal initiative, or any other reason than disability due to disease or injury - to secure gainful employment. The infirmities resulting from advancing years when taken collectively, while not considered a disease entity, may be interpreted to be within the meaning of "disease" as used herein. A person who, at the time of his application for domiciliary care has [ ] been rated 75 percent or more disabled for pension or disability compensation purposes will be held to be prima facie incapacitated within the meaning of this paragraph. (January 1, 1948.)

(2) A permanent disability, as contemplated, is exemplified in chronic, severe types of general medical diseases, such as myocarditis, valvulitis, cardiovascular disease, nephritis, arthritis, etc., and in blindness, loss of parts or use of parts, etc. But injuries or diseases such as reparable hernia, chronic appendicitis, cholecystitis, cholelithiasis, nephrolithiasis, etc., are not essentially permanent, as contemplated, in that surgical intervention may remove the disability. (March 25, 1942.)

(3) "No adequate means of support" -- When an applicant is receiving an income of \$60 or more per month from any source, this fact will be considered prima facie evidence that he has adequate means of support, except when he is in fact contributing in whole or part from such income to the support of a wife, child, mother or father. If the applicant alleges he is contributing to the support of dependents other than these, the alleged circumstances will be submitted to the manager for decision as to eligibility for admission. (April 22, 1946.)

(B) Under subparagraph (D) of R&P R-6047:

informed of the emergent condition of the entitled beneficiary in time to authorize the hospital admission or when requested to issue authorization to cover a hospital admission already effected, will at once notify the superintendent of such hospital as follows: (a) That payment cannot be made by the VA for any hospital service or supplies furnished prior to the date that [request for authorization for admission was made. (Except that where such request for authorization was dispatched to the VA within seventy-two hours after the date and hour of admission, the effective date of authorization will be the admission date. Otherwise the date of request for authorization will be the postmark date of a letter request, dispatch date of a telegraph request or the date a telephonic request is received.)] (b) That - if the hospital concerned is under contract with the VA - all services and supplies furnished the beneficiary must be charged for and paid only at rates in accordance with the terms of the contract. (c) That - if the hospital concerned is not under contract - all services and supplies can be paid for only at rates [considered reasonable and not in excess of those customarily charged the general public for similar services in the hospital where rendered.] (d) That, when possible, prior authority will be requested by the hospital for the furnishing of services or supplies other than those included in a contract, or other than those comprehending ordinary items. (e) But when the procurement of such prior authority is not possible, or when the emergent condition of the beneficiary is too urgent for delay, the hospital may furnish such necessary services or supplies, with the understanding that charges therefor will be subject to determination as to their reasonable necessity by the chief medical officer or his designate. (See also R&P R-6140-6148.)

(C) In the territories and insular possessions of the United States, preference will be given to Federal hospitals, and contracts will be made with private [territorial] or insular hospitals only when Federal hospitals are not available. Authorization of hospitalization [in such territories and possessions] is restricted to hospitals under agreements or contracts and admissions to private [hospitals] not under contract will not be authorized [ ] without prior approval of the chief medical director or his designate: Provided, That when immediate hospitalization is necessary for treatment of an emergent service-connected condition in a war veteran [admission to a non-contract hospital may be authorized] if no Federal or contract private hospital be feasibly available, and that the stipulations specified in (B) (2) are communicated to the superintendent of such noncontract private hospital. While admission to private [hospitals] in the territories and insular possessions will in general be restricted to applicants who had service in a war, such [hospitals] may also be used for applicants who had peacetime service only, if needed for treatment of an emergent service-connected condition. The use of such private [hospitals] is prohibited for applicants who had peacetime service only, if required for treatment of a disease or injury not attributable to military or naval service, or for a service-connected condition that is not medically emergent.



(D) The general principles to be observed in utilization of facilities other than those over which the VA has direct and exclusive jurisdiction will be as follows: Other Government facilities under agreements or private facilities under contracts will be used for the hospitalization of beneficiaries requiring hospital treatment in accordance with the foregoing instructions, only when facilities under direct and exclusive jurisdiction of the VA are not feasibly available, or when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required in the individual case, make it necessary or economically advisable to utilize such other institutions instead of a facility under direct and exclusive jurisdiction of the VA.

Except where prior approval of the chief medical director or his designate is required under the provisions of this paragraph, admissions to other Government, private, State, or municipal hospitals may be authorized by [managers of regional offices and centers with regional office activities through chief medical officers or their designates.] (January 1, 1948.)

(E) Women war veterans, needing treatment, in a medical emergency, for a condition either service connected or not service connected, may be authorized admission to a private hospital not under contract, if a Government or private contract facility is not feasibly available. In these medically emergent cases the authority for admission to a private hospital not under contract will also be authority for payment of vouchers covering necessary services or supplies furnished in accordance with the stipulations specified in subparagraph (B) (2) hereof. (April 22, 1946.)

(F) Managers of regional offices and centers [with regional office activities] through chief medical officers or their designates, are empowered to authorize admission to private hospitals, under contract, of women war veterans suffering from nonservice-connected diseases or injuries, as well as service-connected conditions, in a medical emergency or otherwise; Provided, That a Government facility is not feasibly available; the condition of such beneficiary, if already so hospitalized, will not safely allow of her transfer to a Government facility; or the relative travel involved in admission to a Government facility, the medical condition existing, or the nature of the treatment required, make it advisable or economical to utilize the contract facility.

(G) Pregnancy and [parturition] will not entitle to hospitalization, either in facilities under direct and exclusive jurisdiction of the VA, or in other Government, private, municipal, or State hospitals, [unless complicated by a pathological condition].

(H) The prior approval of the chief medical director or his designate must be secured for the use of private, State, or municipal facilities covered by contracts, and located either within the continental limits of the (Paragraph 6050 continued)

United States or in the insular possessions or territories, for the hospitalization in such facilities of beneficiaries in excess of the number of beds contracted for, except where immediate hospitalization is indicated for treatment of a medically emergent service-connected disease or injury. The number of beds set apart by agreements with other Government facilities, for treatment of VA beneficiaries may be exceeded during any month as necessitated [with the consent of the commanding officer of the hospital concerned]; Provided, That the utilization thereof be correspondingly reduced in other months, so that the average monthly use of such beds, at the end of the fiscal year, will not have exceeded the total allocation.

(I) An applicant whose eligibility for hospitalization (whether for observation or treatment, or whether for a service-connected or nonservice-connected condition) had been determined, whose admission to a [VA] facility had been authorized and who had been supplied transportation therefor, but who, while en route to the designated facility (or en route from it after completion of service and regular discharge, [with transportation furnished to a designated point]), develops an unavoidable and unforeseen medical emergency that forbids continuance of such travel and requires admission to a private hospital or treatment by a private physician, will be entitled to such necessary services at the expense of the Government, including any extra transportation costs (ambulance or otherwise) that were actually necessitated in the circumstances. (1) If the chief medical officer or his designate of the territory concerned is informed of such emergency hospital admission or such physician's treatment before or shortly after the beginning of the services, authorization for the services, followed by payment of bills therefor, may be made in accordance with the terms of (B) (2). (2) If the chief medical officer or his designate had not authorized such hospitalization or such physician's services, he may nevertheless certify for payment bills from the hospital superintendent or the attending physician, provided determination is made of the actual necessity for the items of service rendered, and payment is at fees [considered reasonable and not in excess of those customarily charged the general public for similar services in the hospital where rendered]. (3) Subject to the same controlling conditions as in (2), the chief medical officer or his designate may authorize reimbursement of the beneficiary or his representative if either had paid bills submitted by the superintendent of the hospital or by the physician who had attended the beneficiary, and had submitted those receipted bills.

[(J) Payment or reimbursement for emergency medical treatment and hospitalization through facilities other than governmental as provided in paragraph (I), may be authorized where a veteran granted vocational rehabilitation pursuant to the provisions of Public Law 16, 78th Congress, is furnished transportation and ordered to report to a designated school, proceeds in accordance with said orders and becomes ill while en route, if there is no intervening factor for which he is responsible which would affect or change his status. (A. D. No. 628.)] (January 1, 1948.)



6051. HOSPITALIZATION IN MEDICAL EMERGENCIES.--Prior authority must always be obtained for travel incident to hospital treatment or domiciliary care. Ordinarily such authority will be issued when a veteran is notified of approval of his application, and transportation, meal and lodging requests, as necessitated, are sent to him or his representative. But when an applicant's condition is medically emergent, authority for travel may be extended by telephone or telegraph, subject to the procedure provided therefor. (February 23, 1938.)

#### OUT-PATIENT TREATMENT

6060. OUT-PATIENT TREATMENT.--(A) Out-patient treatment, medical or dental, including necessary medicines, prosthetic appliances and other supplies, may be rendered to the following applicants under the conditions stated: (September 24, 1945.)

(1) [Persons discharged or released from active military or naval service, including those who had active duty as a member of the Women's Army Auxiliary Corps] and officers retired for disability under the provisions of the Emergency Officers Retirement Act (Public No. 506, 70th Congress, as amended) [who served during a period of war as defined in R&P R-6047 (A) (1) and who are in need of treatment for a disease or injury adjudicated by the VA as incurred or aggravated in such war] service.

(2) Persons included in paragraph III, part I, Veterans Regulation No. 1 (a), and paragraph IV, part II, Veterans Regulation No. 1 (a) (approved May 11, 1944), who are in need of treatment for an injury or disease incurred in line of duty and for which they are receiving disability compensation [ ].

(3) Persons retired under the provisions of Public No. 18, 76th Congress, [as amended by] Public Law 262, 77th Congress, who are in need of treatment for a disease or injury determined as incurred or aggravated in line of duty in active service.

(4) Retired members of the Regular Establishment who have elected, under Public Law 314, 78th Congress, to receive [compensation] for a service-connected condition and who are in need of treatment for such condition.

(5) Persons who were [discharged or released under other than dishonorable conditions from active military or naval service] for disability incurred or aggravated in line of duty in active service or who are in receipt of [compensation] for service-connected [or service-aggravated] disability. A formal claim for disability compensation [ ] will not be required of an applicant eligible for out-patient treatment by reason of discharge for disability incurred or aggravated in line of duty; and a denial of a claim for disability compensation [ ] will not debar out-patient treatment for such disability. (See determination of line of duty, [R&P R-6047 (B) (1) (a) and (c)].)

(6) Persons pursuing a course of vocational training authorized under Public Law 16, 78th Congress, who are in need of treatment to avoid interruption of such training.

(7) Persons properly referred by authorized officials of other Federal agencies, for which the Administrator of Veterans Affairs may agree to render such service under conditions stipulated by him, and [pensioners of nations allied with the United States in World War I and World War II when duly authorized]. Charges for treatment of patients of the classes specified herein will be at prescribed rates.

(8) Employees of the VA, their families and the general public in emergencies, subject to conditions stipulated by the Administrator of Veterans Affairs. Charges for treatment of patients specified herein will be at prescribed rates.

(B) While out-patient treatment is primarily authorized only for service-connected [or service-aggravated] conditions, adjunct out-patient treatment for a nonservice-connected condition which is associated with and held to be aggravating disability from a disease or injury service connected [or service aggravated] may be also authorized in accordance with prescribed principles for persons defined in (A) (1) to (5) inclusive. [ ] The opinion of the [branch] medical director may be requested in any individual case where advice as to the propriety of furnishing adjunct treatment is desired. (January 1, 1948.)

#### STATUTORY DISCHARGE OF ACTIVELY TUBERCULOUS PATIENTS

6065. (A) Beneficiaries with active tuberculosis, the disability from which has been adjudicated as attributable to service in World War I who have been hospitalized for a continuous period of one year under proper medical supervision; whose condition, it is adjudged, will not reach arrest by further hospitalization; and whose discharge from hospital treatment will not be prejudicial to themselves or their families, will be potentially eligible for the statutory hospital discharge authorized in section 202 (3), World War Veterans' Act, 1924, as provided by Public No. 141, 73d Congress. (See medical procedure.) (September 24, 1945.)

(B) Actively tuberculous patients whose discharge from hospital treatment under (A) is not disapproved by the chief medical officer or clinical director will be so discharged if proper investigation by the office concerned discloses the following necessities of home environment: A sanitary domicile where reasonable comforts and care can be provided, such as a well-ventilated room or porch, good food, fresh air, etc.; relatives or friends who can assume the obligations of continued nursing care, who know how properly to safeguard themselves from infection by proper disposition of the patient's sputum,



and who can furnish, on forms supplied by the VA, the information necessary for administrative supervision; feasibility of keeping infants and young children from infection by the patient; facilities to provide for not less than 18 hours a day in bed or in a "curing chair."

(C) Discharge, not under Public No. 141, 73d Congress, where there has not been one year's continuous hospitalization. Beneficiaries suffering from active tuberculosis who have not had one year's continuous hospitalization under proper medical supervision, but who fulfill all other conditions specified in subparagraph (A) hereof, may be permitted discharge from hospital treatment for "maximum benefit," but not under the provisions calling for the post-hospital statutory award in section 202 (3), World War Veterans' Act, 1924, as provided by Public No. 141, 73d Congress. If there is probability of further improvement of these patients by hospitalization, it will be continued. (December 1, 1937.)

#### DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL TREATMENT OR DOMICILIARY CARE

6066. AUTHORITY FOR DISCIPLINARY ACTION.--[(A)] The good conduct of beneficiaries receiving hospitalization for observation and examination or for treatment, or receiving domiciliary care in facilities under direct and exclusive jurisdiction of the VA, will be maintained by corrective and disciplinary procedure formulated by the VA. Such corrective and disciplinary measures, to be selectively applied in keeping with the comparative gravity of the particular offense, will consist, in respect to hospital patients, of the withholding for a determined period of pass privileges, exclusion from entertainments, or disciplinary discharge; and, in respect to domiciled members, such penalties as confinement to barracks or grounds, deprivation of privileges, performance of extra duty without pay for a stated period, enforced furlough or dropping from rolls.

[(B)] Discharge for infraction of hospital discipline will carry the accompanying penalty of exclusion from rehospitalization except in a medical emergency, and from domiciliation, for a prescribed period, with denial of Government transportation to cover return travel upon such discharge or to cover rehospitalization in a medical emergency, unless the offender executes affidavit of inability to defray the expenses of such travel. Likewise, exclusion from domiciliary care for a stated period will exclude an offender from hospital treatment (except in a medical emergency), for such stated period.

[(C) The penalties prescribed in (B) will be applicable to those persons receiving hospitalization in other Government or private facilities as beneficiaries of the VA and members of State Soldiers' Homes on whose behalf said home is receiving Federal aid payments, who are discharged therefrom for an offense similar in nature for which the VA would give an irregular discharge if such persons had been patients or members in a VA hospital or center.] (January 1, 1948.)

restored to active duty, required to engage in combat, or killed in combat. If the insured died while the insurance was continued in force as provided above, payment of the benefits shall be made directly from the National Service Life Insurance Appropriation, and any premiums due on such insurance shall be deducted from the proceeds of the insurance.

(B) The provisions of the foregoing subparagraph shall not apply to any insurance forfeited under section 612 of the National Service Life Insurance Act, as amended. (August 1, 1946.)

## REINSTATEMENT

3422. REINSTATEMENT OF NATIONAL SERVICE LIFE INSURANCE.-- Subject to the provisions of the National Service Life Insurance Act, as amended, and regulations issued thereunder, any insurance which has lapsed or may hereafter lapse and which has not been surrendered for a cash value or for paid-up insurance, may be reinstated upon written application signed by the applicant, and, except as hereinafter provided, upon payment of all premiums in arrears, with interest from their several due dates, provided such applicant at the time of application and tender of premiums is in the required state of health as shown in clause (A) or (B) of R&P R-3423, whichever is applicable, and submits evidence thereof at the time of application and tender of premiums as may be satisfactory to the Administrator of Veterans Affairs: Provided, That interest on premiums in arrears shall be at the rate of five per centum per annum, compounded annually, to the first monthly premium due date after July 31, 1946, and thereafter at the rate of four per centum per annum, compounded annually: Provided further, That the payment or reinstatement of any indebtedness against any policy must be made, and if such indebtedness with interest exceeds the reserve of the policy at the time of application for reinstatement thereof, then the amount of such excess shall be paid by the applicant as a condition of the reinstatement of the indebtedness and of the policy: Provided further, That a lapsed National Service Life Insurance policy which is in force under extended term insurance may be reinstated without health statement or other medical evidence, if application and tender of premiums with interest are made not less than five years prior to the date such extended insurance would expire: Provided further, That in any case in which the extended insurance under an endowment policy provides protection to the end of the endowment period such policy may be reinstated upon application and payment of the premiums with interest, and health statement or other medical evidence will not be required: And, provided further, That National Service Life Insurance on the level premium term plan may be reinstated by written application of the insured accompanied by evidence of insurability and tender of two monthly premiums, but such insurance when reinstated without payment of all premiums in arrears with interest shall have no reserve value. Except as provided in R&P R-3484, application for reinstatement of level premium term insurance accompanied



by evidence of insurability and tender of premiums must be submitted prior to the expiration of the five-year term period.

When the insured under a National Service Life Insurance policy on the level premium term plan makes inquiry prior to the expiration of the grace period disclosing a clear intent to continue insurance protection, such as a request for information concerning premium rates or conversion privileges, etc., an additional reasonable period not exceeding sixty days may be granted for payment of premiums due; but the premiums in any such case must be paid during the lifetime of the insured. (August 1, 1946.)

3423. HEALTH REQUIREMENTS.--National Service Life Insurance on any plan may be reinstated if application and tender of premiums are made:

(A) On or before July 31, 1948, or within three months after lapse, whichever is later, provided the applicant be in as good health on the date of application and tender of premiums as he was on the due date of the premium in default and furnishes evidence thereof satisfactory to the Administrator.

(B) Subsequent to July 31, 1948, and after expiration of the three-month period mentioned in subparagraph (A) hereof, provided applicant is in good health (R-3401) on the date of application and tender of premiums and furnishes evidence thereof satisfactory to the Administrator of Veterans Affairs. (January 9, 1948.)

3424. APPLICATION AND MEDICAL EVIDENCE.--The applicant for reinstatement of National Service Life Insurance, during his lifetime and before becoming totally disabled, must submit a written application signed by him and furnish evidence of health as required in R&P R-3423 at the time of application satisfactory to the Administrator of Veterans Affairs and upon such forms as the Administrator shall prescribe or otherwise as he shall require. Applicant's own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement under R&P R-3423(A), but, whenever deemed necessary in any such case by the Administrator, report of physical examination may be required. Applications for reinstatement submitted after expiration of the applicable period mentioned in R&P R-3423(A) must be accompanied by report of physical examination made in accordance with the provisions of R&P R-3464: Provided, That if the insurance becomes a claim after the tender of the amount necessary to meet reinstatement requirements but before full compliance with the requirements of this paragraph, and the applicant was in a required state of health at the date that he made the tender of the amount necessary to meet reinstatement requirements, and that there is satisfactory reason for his noncompliance, the Director, Underwriting Service, in Central Office cases, and the Director, Insurance Service, in branch office cases, may, if the applicant be dead, waive any or all requirements of this paragraph (except payment of the necessary premiums)

or, if the applicant be living, allow compliance with this paragraph as of the date the required amount necessary to reinstate was received by the VA.】 (February 4, 1948.)

3426. DIVIDENDS.--A National Service Life Insurance policy shall participate in and receive such dividends from gains and savings as may be determined by the Administrator of Veterans Affairs. Dividends will be paid in cash except that at the request of the insured they may be left to accumulate on deposit provided the policy is in force on a basis other than extended term insurance or level premium term insurance. Interest on dividend accumulations will be credited annually at such rate as the Administrator of Veterans Affairs may determine. Dividend accumulations shall not be available for the payment of insurance premiums but will be used in addition to the reserve on the policy for the purpose of computing the period of extended term insurance or the amount of paid-up insurance as provided in R&P R-3429 and R-3430, respectively. Any dividend accumulations not previously withdrawn will be payable at the maturity of the policy to the person entitled to its proceeds. (March 31, 1947.)

3427. CASH VALUE - OTHER THAN FIVE-YEAR LEVEL PREMIUM TERM POLICY.--Provisions for cash value, paid-up insurance, and extended insurance under National Service Life Insurance on any plan other than the five-year level premium term plan shall become effective at the completion of the first policy year; all values, reserves, and net single premiums being based on the American Experience Table of Mortality, with interest at the rate of 3 per centum per annum. The cash value at the end of the first policy year and at the end of any policy year thereafter, for which premiums have been paid in full, shall be the reserve together with any dividend accumulations. For each month after the first policy year, for which month a premium has been paid, the reserve at the end of the preceding policy year shall be increased by one-twelfth of the increase in reserve for the current policy year. Upon written request therefor and upon complete surrender of the policy with all claims thereunder, the United States will pay to the insured the cash value of the policy less any indebtedness. (October 8, 1940.)





## MEDICAL

### TUBERCULOSIS; DIAGNOSTIC CRITERIA

6021. [CRITERIA FOR TUBERCULOUS DISEASE.--(A) A claimant will be held to have had "a tuberculous disease," as related to determination of its complete arrest for the purposes of the statutory award, when the case history includes clinical and other records indicating previously active tuberculosis, the diagnosis of which, in the case of pulmonary tuberculosis, will have been supported by the findings specified in R. & P. R-6022.

(B) It must be definitely understood that a claimant now presenting wholly negative physical and X-ray findings and without any clinical evidence of tuberculosis may have had an unmistakably manifest pulmonary tuberculosis in the not remote past, and that present negative findings will not outweigh a significant history and findings indicative of former active tuberculosis.

(C) Excepted from the requirement as to findings in (A) hereof are cases in which a diagnosis of active pulmonary tuberculosis appears in official service records, and has not been revised upon the basis of other medical evidence, covering a reasonable period after discharge from service, which establishes that the condition is due to some pathologic process other than tuberculosis. In such cases, the diagnosis in the official service records will be accepted, even if not supported by the findings specified in R. & P. R-6022.

(D) The exception defined in (C) accords with the principle of attaching full weight to records of the Army and Navy relative to injury or disease of claimants during military or naval service, when other evidence and considerations do not show such records to be incorrect. Service connection of disability predicated upon a diagnosis of active tuberculosis by the Army or Navy, and consequent statutory awards in effect March 19, 1933 are entitled to the protection afforded by sections 27 and 28, Public No. 141, 73d Congress. However, the authority in (C) is not to be interpreted as compelling service connection for disability from active tuberculosis. The intent of that exception is to insure appropriate recognition of a diagnosis of active tuberculosis that had been made during the claimant's military or naval service, medical officers of the Army and Navy not being informed at that time of the requirements of the Veterans Administration governing the diagnosis of active pulmonary tuberculosis as set forth in R. & P. R-6022.] (March 25, 1942.)

6022. FINDINGS REQUIRED FOR THE DIAGNOSIS OF ACTIVE PULMONARY TUBERCULOSIS.--A diagnosis of active pulmonary tuberculosis will be considered as established upon consideration of the following findings:

(A) Sputum positive for tubercle bacilli.

[(B) Pleurisy with effusion, in retrospect, if followed sometime later by clinical pulmonary tuberculosis (without obvious cause therefor, such as acute lobar pneumonia, acute bronchial influenza or trauma); or if followed by peritoneal or possibly some other form of extra-pulmonary tuberculosis. This rule will not apply in dry pleurisy, or in pleural exudates or transudates due to cardiac, cardiorenal or malignant disease.



(C) Authentic hemoptysis.

(D) Cavity or pneumothorax diagnosed by stereogram and physical examination.

(E) A condition evidenced by definite physical findings suggestive of tuberculous involvement, the most characteristic of which are typical indeterminate, localized, persistent moist rales (commonly called crepitant and subcrepitant) in the upper lobes, increased or manifested on the first inspiration after a forced expiration followed by a cough.

(F) X-ray findings, of which roentgenograph stereograms manifesting cottony densities, cirrus clouding, or areas of rarefaction surrounded by annular shadows interpreted as cavities, diagnostic of tuberculous infiltration, caseation, or cavitation are the most important. (Unsupported X-ray findings will not, however, be accepted as conclusive evidence of activity.)

(G) A condition evidenced by definite toxemia of probable tuberculous origin, manifested by one or more of these symptoms: Fever, loss of weight and rapid "resting" pulse.

Any two or more of the foregoing findings, (A) to (G), will establish the diagnosis of active pulmonary tuberculosis. But, of this list, the first three, (A) to (C) inclusive, will be held as relatively more important; and any one of the said first three will be considered acceptable evidence of active pulmonary tuberculosis, in the absence of any other cause which would explain its exhibition. The absence of the other findings, (D) to (G) inclusive, is to be considered of less importance than the presence of any one of the first three, (A) to (C) inclusive.] (March 25, 1942.)

6023. FINDINGS NOT TO BE REGARDED AS EVIDENCE OF ACTIVE PULMONARY TUBERCULOSIS.-- The following signs will NOT be regarded as evidence of pulmonary disease in the absence of other signs in the same portion of the lungs:

(A) Slightly harsh breathing, slightly prolonged expiration over the right apex above the clavicle anteriorly and to the third dorsal vertebra posteriorly. The same signs at the extreme apex, left side.

(B) Same signs second interspace right, anteriorly, near sternum (proximity of right main bronchus.)

(C) Increased vocal resonance, slightly harsh breathing immediately below center of left clavicle.

(D) Fine crepitations over sternum, heard when stethoscope touches the edge of that bone.

(E) Clicks heard during strong respiration or after cough in the vicinity of the sternocostal articulations.

(F) The so-called atelectatic rales heard at the apex during the first inspiration which follows a deeper breath than usual, or a cough.

(G) Sound resembling rales at base of lung (marginal sounds) especially marked in right axilla, limited to inspiration.

(H) Similar sounds heard at apex of heart on cough (lingula).

(I) Slightly prolonged expiration at left base posteriorly.

(J) Very slight harshness of respiratory sounds with prolonged expiration in the lower paravertebral regions of both lungs posteriorly, most marked at about angle of scapula, disappearing a short distance above that point, equal on both sides, or slightly more marked at the angle of one side, more frequently the left.

## MEDICAL

### APPOINTMENTS

6030. WHERE CLAIMANTS REFUSE TREATMENT BY UNNECESSARILY BREAKING APPOINTMENTS.--In any case where a claimant under out-patient medical or dental treatment breaks an appointment, without a reasonable excuse for such action, he will be informed that a repetition of the offense will be deemed to be a refusal of Government treatment. In any case where a claimant under out-patient medical or dental treatment, has broken an appointment without a reasonable excuse, and has been advised that a repetition of the offense will be construed as a refusal to accept Government treatment, and a second appointment is broken thereafter, without at least 24 hours notice, or a reasonable excuse, it will be deemed that the claimant has refused Government treatment. Thereafter no further treatment will be furnished until claimant has made a specific formal application therefor and has satisfactorily evinced a willingness to accept Government treatment and to cooperate with the Government agency providing the treatment, by keeping his appointments, or by giving at least 24 hours notice where an appointment must necessarily be broken. Where an appointment is broken without notice and satisfactory reasons are shown for the breaking of the appointment, and it is also satisfactorily shown that circumstances attending the breaking of the appointment were such that notice could not be given, the claimant will not be deemed to have refused treatment. Nothing in this paragraph will be construed to prevent a claimant from receiving the benefit of treatment for an emergency condition that may arise during the time when he has been determined to be "Not entitled to treatment" as a result of refusal..

### EMERGENCY HOSPITALIZATION

6035. GENERAL AUTHORITY FOR EMERGENCY HOSPITAL TREATMENT.--All potential beneficiaries having prima facie entitlement therefor, who are in need of emergency hospital treatment, may be provided therewith, and such emergency hospital treatment may, if necessary, be continued until a definite decision is reached as to the eligibility of the applicant for medical treatment. This authority for emergency hospitalization carries authority to supply Government transportation and necessary meals and lodging en route to the facility designated for the emergency admission. Emergency hospitalization may also be provided applicants who have not completed a prescribed period of exclusion from hospitalization, imposed because of infraction of facility discipline; but Government transportation (and necessary meals and lodging en route) will not be supplied these applicants, unless they execute affidavit that they are unable to defray the expense of travel to the facility designated. (March 25, 1942.)



## MEDICAL TREATMENT IN FOREIGN COUNTRIES

6036. No person shall be entitled to receive domiciliary, medical or hospital care, including treatment, who resides outside of the continental limits of the United States or its territories or possessions, except that the medical director may authorize hospitalization, including medical treatment, determined necessary for diseases or injuries adjudicated as incurred in or aggravated by active military or naval service in a period of war, for applicants temporarily sojourning or temporarily residing in a foreign country, who are citizens of the United States. (See R. & P. 7600.) (February 15, 1941.)

## HOSPITALIZATION AND DOMICILIARY CARE

6045. PERSONS ENTITLED TO HOSPITAL OBSERVATION AND PHYSICAL EXAMINATION.--Hospitalization for observation and physical (including mental) examination may be effected when requested by an authorized official, or when found necessary in physical examination of the following persons:

(A) Claimants or beneficiaries of the Veterans Administration, for purposes of disability compensation, pension, emergency officers retirement pay, [medical feasibility for vocational training under Public No. 16, 78th Congress, and Government insurance.]

(B) Claimants or beneficiaries referred from a facility to a diagnostic center for study to determine the clinical identity of an obscure disorder, or for advice as to treatment.,

(C) Employees of the Veterans Administration, when necessary to determine their mental or physical fitness to perform official duties.

(D) Claimants or beneficiaries of other Federal agencies: (1) Bureau of War Risk Litigation, Department of Justice - plaintiffs in Government insurance suits. (2) United States Civil Service Commission - annuitants or applicants for retirement annuity, and such examinations of prospective appointees as may be requested. (3) United States Employees Compensation Commission - to determine identity, severity or persistence of disability. (4) Railroad Retirement Board - applicants for annuity under Public No. 162, 75th Congress. (5) Other Federal agencies.

(E) Pensioners of nations allied with the United States in [World War I] upon authorization from accredited officials of the respective governments. (October 8, 1945.)

6046. PERSONS ENTITLED TO HOSPITAL TREATMENT OR DOMICILIARY CARE.--Hospital treatment or domiciliary care may be provided:

(A) Subject to the eligibility provisions of R-6047 and R-6048, for:

(1) Persons discharged from the United States Army, Navy, Marine Corps or Coast Guard, after service in a war or peacetime period; retired emergency officers of the World War.

(2) Persons retired from the Army, Navy, Marine Corps or Coast Guard, including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had served honorably during a war period (Public No. 198, 76th Congress, [as amended by Public No. 365, 77th Congress]).

[(3) Persons retired from the Army of the United States under Public No. 18, 76th Congress, as amended by Public No. 262, 77th Congress.

(4) Persons retired from the Army, Navy, Marine Corps or Coast Guard, Regular Establishment, not having had war service who elect to receive pension or compensation under laws administered by the Veterans Administration in lieu of retirement pay (Public No. 314, 78th Congress).]

(B) Not subject to the eligibility provisions of R-6047 and R-6048, for:

(1) Persons in active service with the United States Army [(Public No. 177 and] Public No. 852, 76th Congress), or United States Navy or Marine Corps (Public No. 675, 70th Congress), when duly referred with authorization therefor, may be supplied hospital treatment. Emergency treatment may be rendered such persons upon their own application, when absent from their commands, provided that covering formal authorization be procured as promptly as possible after the emergency treatment is begun. (See R. & P. 6018 and 6019.)

(2) Hospital treatment may be provided, upon authorization, for beneficiaries of the United States Public Health Service, Employees Compensation Commission and [other Federal agencies]. (See R. & P. 6020, 6022, [ ] and 6025.)

(3) Pensioners of nations allied with the United States in World War I may be supplied hospital treatment when duly authorized. (See R. & P. 6026.)

(C) Emergency hospital treatment may be provided for:

(1) Persons having no prima facie eligibility therefor, as a humanitarian service. (2) Persons admitted because of presumed discharge or retirement from the armed forces, but subsequently found to be ineligible as such. (3) Employees (not potentially eligible as ex-members of the armed forces) and members of their families, when residing on reservations of field stations of the Veterans Administration, and when they cannot feasibly obtain emergency treatment from private facilities. (See R. & P. 6027, 6028 and 6029.)

(D) Persons comprehended under the provisions of (B) and (C) may be supplied hospitalization after the needs of emergency applicants under (A) are fully met. See R. & P. [6018]-6029 as to per diem rates for persons hospitalized under (B) and (C). (October 8, 1945.)

6047. ELIGIBILITY FOR HOSPITAL TREATMENT OR DOMICILIARY CARE OF PERSONS DISCHARGED OR RETIRED FROM MILITARY OR NAVAL SERVICE.--Within the limits of Veterans Administration facilities, hospital treatment or domiciliary care may be furnished the following applicants in the specified order of preference:

(A) Hospital treatment for: (1) Persons who served during the period of [World War I] as defined in paragraphs I and IV, Veterans Regulation No. 10, as amended; or in any war prior to the Spanish-American War; or during the Spanish-American War, Philippine Insurrection or Boxer Rebellion from April 21, 1898 to July 4, 1902 (or to July 15, 1903, if the service was in Moro Province), or on or after December 7, 1941, and before the termination of hostilities in World War II (as determined by proclamation of the President or by concurrent resolution of the Congress), including those who had active duty as a member of the Women's Army [ ] Corps, Women's Reserve of the Navy and Marine Corps and the Women's Reserve of the Coast Guard - when [discharged under other than dishonorable conditions from a period of war service, and when suffering from an injury or disease incurred or aggravated in line of duty in that period of] active military or naval service, and for which they are medically determined to be in need of hospital treatment.



(2) Retired officers and retired enlisted men of the Army, Navy, Marine Corps and Coast Guard, including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had honorable service in a period of war, as defined in (A)(1) hereof, and are medically determined to need hospital treatment for an injury or disease that was incurred in line of duty in active military or naval service (Public No. 198, 76th Congress; Public No. 365, 77th Congress).

(3) Persons included in paragraph III, Part I, Veterans Regulation No. 1 (a), who are suffering from injuries or diseases incurred in line of duty, for which they are receiving disability compensation, and for which they are in need of hospital treatment.

[(4) Persons included in Public No. 300, 78th Congress, who, on or after December 7, 1941 and prior to the termination of present hostilities, suffered or shall suffer an injury or disease in line of duty for which they are receiving disability compensation or pension and for which they are in need of hospital treatment.]

(B) Hospital treatment for: (1) Officers and enlisted personnel of the Army, Navy, Marine Corps and Coast Guard, or reserve officers and members of the Enlisted Reserve, or officers and enlisted men of the National Guard of the United States, or persons accepted for selective training, who were [discharged under other than dishonorable conditions] from Federal service for disability incurred in line of duty, or who are in receipt of pension for service-connected disability, when suffering from injuries or diseases incurred or aggravated in line of duty in active Federal service, and for which they are medically determined to be in need of hospital treatment. Cadets and midshipmen discharged from the academies at West Point and Annapolis, who meet these requirements as to character of discharge or receipt of pension are eligible under this subparagraph, regardless of the requirement as to active military or naval service. [(See also section 10, Public No. 144, 78th Congress.)]

[(a)] For applicants not in receipt of pension for service-connected disability, the official records of the Army or Navy, respectively, relative to findings of line of duty for its purposes, will be accepted in determining eligibility for hospital treatment under this subparagraph (B); except that where the official records of the Army or Navy show a finding of disability not incurred in line of duty and evidence is submitted to the Veterans Administration which permits of a different finding, the decision of the Army or Navy will not be binding upon the Veterans Administration, which will be free to make its own determination of line of duty in accordance upon the evidence so submitted. It will be incumbent upon the applicant to present such controverting evidence and, until he so acts and a determination favorable to him is made by the Veterans Administration, the finding of the Army or Navy will control and hospitalization will not be authorized. Such controverting evidence, when received from an applicant, will be referred to the adjudicating agency which would have jurisdiction if the applicant were filing claim for pension or disability compensation, and the determination of such agency as to line of duty, which is promptly to be communicated to the manager of the facility receiving the application for hospitalization, will govern his disapproval or approval of admission, other eligibility requirements having been met. Where the official records of the Army or Navy show that the disability on account of which a veteran was discharged or [separated from his peacetime service under other than dishonorable conditions] was incurred in line of duty, such showing will be accepted for the purpose of determining his eligibility for hospitalization, notwithstanding the fact that the Veterans Administration has made a determination in connection with a claim for monetary benefits that the disability was incurred not in line of duty. See also Public No. 648,

(2) Domiciliary care for persons enumerated in subparagraph (C) (1), when suffering from a permanent disability or tuberculous or neuropsychiatric ailment and who are incapacitated from earning a living and who have no adequate means of support. If a member is discharged on his own request or at the expiration of seven days following an authorized pass or leave of absence, it will be presumed he no longer regards himself as incapacitated from earning a living. Under such circumstances he will not be furnished hospitalization or domiciliary care until the expiration of one month from the date of such discharge, except when requiring readmission in a medical emergency. (June 19, 1947)

(3) Retired personnel of the classes comprehended by subparagraph (B) (2) may be supplied hospital treatment in a hospital or center under the direct and exclusive jurisdiction of the VA, if beds are available, and such applicants agree to pay the per diem rate to cover subsistence, which is set by the Administrator of Veterans Affairs.

**(D) Hospital treatment or domiciliary care for:**

(1) Persons who serve in the active military or naval forces, including those who had active duty as a member of the women's army auxiliary corps, regardless of length of service, during a period of war as defined in subparagraph (A) (1), who were (a) discharged or released from active duty under other than dishonorable conditions; (b) who swear that they are unable to defray the expense of hospitalization or domiciliary care (including the expense of transportation to and from a VA facility); and (c) who are suffering from a disability, disease or defect which, being susceptible of cure or decided improvement, indicates need for hospital care, or which, being essentially chronic in type and not susceptible of cure, or decided improvement by hospital care, is producing disablement of such degree and of such probable persistency as will incapacitate from earning a living for a prospective period, and thereby indicates need for domiciliary care. Except for applicants presenting emergent conditions, consideration in admissions under this subparagraph may be given to the length or character of service.

(2) Persons retired from active military or naval service including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay, who had honorable service in a period of war, as defined in (A) (1) hereof, and who meet the other eligibility requirements of (1) hereof (Public No. 198, 76th Congress; Public Law 365, 77th Congress). (January 1, 1948)

(3) If a member is discharged on his own request or at the expiration of seven days following an authorized pass or leave of absence, it will be presumed he no longer regards himself as incapacitated from earning



a living. Under such circumstances he will not be furnished hospitalization or domiciliary care until the expiration of one month from the date of such discharge except when requiring readmission in a medical emergency. (June 19, 1947)

#### 6048. DEFINITIONS APPLICABLE IN DETERMINING ELIGIBILITY FOR HOSPITAL TREATMENT OR DOMICILIARY CARE

##### (A) Under subparagraph (C) (2) of R&P R-6047:

(1) A "permanent disability" will be taken to mean such impairment of mind or body as may reasonably be expected to continue throughout the remainder of the applicant's life, or any condition listed in R&P R-1086. A permanent disability must be such as would materially interfere with the following of any substantially gainful occupation. This must be for medical determination, which shall not be influenced by the applicant's inability--due to industrial conditions, lack of personal initiative, or any other reason than disability due to disease or injury--to secure gainful employment. The infirmities resulting from advancing years when taken collectively, while not considered a disease entity, may be interpreted to be within the meaning of "disease" as used herein. A person who, at the time of his application for domiciliary care has been rated 75 percent or more disabled for pension or disability compensation purposes will be held to be prima facie incapacitated within the meaning of this paragraph. (January 1, 1948)

(2) A permanent disability, as contemplated, is exemplified in chronic, severe types of general medical diseases, such as myocarditis, valvulitis, cardiovascular disease, nephritis, arthritis, etc., and in blindness, loss of parts or use of parts, etc. But injuries or diseases such as reparable hernia, chronic appendicitis, cholecystitis, cholelithiasis, nephrolithiasis, etc., are not essentially permanent, as contemplated, in that surgical intervention may remove the disability. (March 25, 1942)

(3) "No adequate means of support" -- When an applicant is receiving an income of **[\$100]** or more per month from any source, this fact will be considered prima facie evidence that he has adequate means of support, except when he is in fact contributing in whole or part from such income to the support of a wife, child, mother or father. If the applicant alleges he is contributing to the support of dependents other than these, the alleged circumstances will be submitted to the Manager for decision as to eligibility for admission. (March 30, 1948)

##### (B) Under subparagraph (D) of R&P R-6047:

employment. The infirmities resulting from advancing years when taken collectively, while not considered a disease entity, may be interpreted to be within the meaning of "disease" as used herein. A person who, at the time of his application for domiciliary care has recently been rated 75 percent or more disabled for pension or disability compensation purposes will be held to be prima facie incapacitated within the meaning of this paragraph.

(2) A permanent disability, as contemplated, is exemplified in chronic, severe types of general medical diseases, such as myocarditis, valvulitis, cardiovascular disease, nephritis, arthritis, etc., and in blindness, loss of parts or use (Paragraph 6048 continued)





of parts, etc. But injuries or diseases such as reparable hernia, chronic appendicitis, cholecystitis, cholelithiasis, nephrolithiasis, etc., are not essentially permanent, as contemplated, in that surgical intervention may remove the disability. (March 25, 1942.)

(3) "No adequate means of support" -- When an applicant is receiving an income of \$60 or more per month from any source, this fact will be considered prima facie evidence that he has adequate means of support, except when he is in fact contributing in whole or part from such income to the support of a wife, child, mother or father. If the applicant alleges he is contributing to the support of dependents other than these, the alleged circumstances will be submitted to [the manager] for decision as to eligibility for admission. [ ] (April 22, 1946.)

(B) Under subparagraph (D) of R. & P. R-6047:

(1) "Any disability, disease or defect" will comprehend any acute, sub-acute or chronic disease (of a general medical, tuberculous or neuropsychiatric type) or any acute, subacute or chronic surgical condition, susceptible of cure or decided improvement by hospital care; or any condition which, not susceptible of cure or decided improvement by hospital care, indicates need for domiciliary care. Domiciliary care, as the term implies, is the provision of a home, with such incidental medical care as is needed. To be entitled to domiciliary care the applicant must consistently have a disability, disease or injury which, chronic in type and not susceptible of cure or decided improvement by hospitalization, is producing disablement of such degree and probable persistency as will incapacitate from earning a living for a prospective period. Defects such as constitutional psychopathic inferiority or mental deficiency, without superimposed psychosis or psychoneurosis, will not indicate hospital treatment, but will entitle to domiciliary care, other requirements being met, if such defects are producing material social and industrial inadaptability.

(2) "Unable to defray expenses of hospitalization or domiciliary care, including transportation to and from a Veterans Administration facility." The affidavit of the applicant on Form P-10 that he is unable to defray the expenses of hospitalization or domiciliary care, including transportation to and from a hospital or home, will constitute sufficient warrant to furnish Government transportation to cover transportation to the hospital or home. But, having in mind the penal provisions of the law governing the making of false sworn statements, managers will report to central office any and all cases in which they suspect false statements as to inability to defray the expenses of hospitalization or domiciliary care, including transportation. Such reports will include all the facts, with comment and recommendation. (March 25, 1942.)

(C) Persons applying for hospital treatment under [subparagraph] (C) or (D) of R. & P. R-6047 and who are potentially entitled to other hospital treatment [or to reimbursement for the costs of hospital treatment] because of membership in a union, fraternal organization, or group hospitalization plan under commercial insurance companies policies covering illness or injury; or as beneficiaries of a State Industrial Commission or Employees Compensation Commission, etc., will [not be furnished hospital treatment] without charge therefor to the extent of such reimbursement. Action will be taken to effect collection from the persons, companies, organizations or agencies (other than Federal) in the amounts determined payable under the terms of the applicable insurance policy, plan, agreement or other undertaking. (April 22, 1946.)



6050. UTILIZATION OF FACILITIES OTHER THAN THOSE UNDER DIRECT AND EXCLUSIVE JURISDICTION OF THE VETERANS ADMINISTRATION.--For the purposes of Veterans Regulation No. 10 (b), Paragraph XIX, defining "Veterans Administration facilities" [and section 1500, Public No. 346, 78th Congress, granting authority to the Administrator of Veterans Affairs "To enter into contracts or agreements with private or public agencies or persons for necessary service, including personal services, as he may deem practicable"], the following provisions will govern in authorizing admissions to facilities other than those under the direct and exclusive jurisdiction of the V. A.:-

(A) Hospitalization will not be authorized in Government facilities other than those over which the V. A. has direct and exclusive jurisdiction until agreement covering such service has been approved. Such agreements, [ ] will not be entered into until careful consideration has been given to the best interests of both the Government and beneficiaries.

(B) (1) [Private facilities will not be used for hospitalization of beneficiaries except when facilities under direct and exclusive jurisdiction of the V. A. or other Government facilities under agreement are not feasibly available, or when the physical or mental condition of beneficiaries will not allow of their transfer thereto from a private, State or municipal hospital. Male beneficiaries in need of treatment of an emergent condition (a) arising from a service-connected disorder; (b) which in medical judgment requires treatment to prevent interruption of training authorized under Public No. 16, 78th Congress, or (c) pending adjudication of a claim for compensation or pension upon determination properly made by the chief medical officer or his designate, that prima facie service connection is established by the evidence of record, including the veteran's statement, may be authorized hospitalization in any private, State or municipal hospital, preferably one under contract. In such medically emergent cases authorization of admission to a private, State or municipal hospital may be given, subject to the conditions stipulated in (2) hereof: and, when so given, will be authority for payment of vouchers covering the cost of such hospitalization. Hospitalization of male beneficiaries in a private, State or municipal hospital under contract may also be authorized for treatment of (a) a non-emergent service-connected condition; (b) that condition determined as incurred or aggravated in line of duty in active Federal service and for which the applicant was discharged under conditions other than dishonorable, provided service connection for such disability has not been denied by the V. A. and (c) a non-emergent nonservice-connected condition which in medical judgment requires treatment to prevent interruption of training authorized under Public No. 16, 78th Congress, provided facilities under direct and exclusive jurisdiction of the V. A. or other Government facilities under agreement are not feasibly available.]

(2) The chief medical officer or his designate, of the regional office or [center] having jurisdiction of the territory in which the concerned private, State, or municipal hospital, contract or non-contract, is located, when informed of the emergent condition of the entitled beneficiary in time to authorize the hospital admission or when requested to issue authorization to cover a hospital admission already effected, will at once notify the superintendent of such hospital as follows: (a) That payment cannot be made by the V. A. for any hospital service or supplies furnished prior to the date that authorization for admission had been issued, and that such authorization cannot be retroactively dated when issued; (except that authorization may be made retroactive to include a period not exceeding [seventy-two hours beginning with the hour of admission to the hospital, provided admission had been officially reported to the regional office or center within such period]). (b) That - if the hospital concerned is under contract with the V. A. - all services and supplies furnished the beneficiary must be charged for and paid only at rates in accordance with the

terms of the contract. (c) That - if the hospital concerned is not under contract - all services and supplies can be paid for only at rates in accordance with the schedule of fees, V. A. (d) That, when possible, prior authority will be requested by the hospital for the furnishing of services or supplies other than those included in a contract, or other than those comprehending ordinary items. (e) But when the procurement of such prior authority is not possible, or when the emergent condition of the beneficiary is too urgent for delay, the hospital may furnish such necessary services or supplies, with the understanding that charges therefor will be subject to determination as to their reasonable necessity by the chief medical officer or his designate. (See also R. & P. R-6140-6148.)

(C) In the territories and insular possessions of the United States, preference will be given to Federal hospitals, and contracts will be made with private or insular hospitals only when Federal hospitals are not available. Authorization of hospitalization by managers of insular offices is restricted to hospitals under agreements or contracts and admissions to private facilities not under contract will not be authorized in territories or insular possessions without prior approval of the [chief medical director or his designate]: Provided, That when immediate hospitalization is necessary for treatment of an emergent service-connected condition in a war veteran, the manager may authorize admission to a non-contract hospital if no Federal or contract private hospital be feasibly available, and that the stipulations specified in (B) (2) are communicated to the superintendent of such non-contract private hospital. While admissions to private facilities in the territories and insular possessions will in general be restricted to applicants who had service in a war, such facilities may also be used for applicants who had peace-time service only, if needed for treatment of an emergent service-connected condition. The use of such private facilities is prohibited for applicants who had peace-time service only, if required for treatment of a disease or injury not attributable to military or naval service, or for a service-connected condition that is not medically emergent.

(D) The general principles to be observed in utilization of facilities other than those over which the V. A. has direct and exclusive jurisdiction will be as follows: Other Government facilities under agreements or private facilities under contracts will be used for the hospitalization of beneficiaries requiring hospital treatment [ ] in accordance with the foregoing instructions, only when facilities under direct and exclusive jurisdiction of the V. A. are not feasibly available, or when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required in the individual case, make it necessary or economically advisable to utilize such other institutions instead of a facility under direct and exclusive jurisdiction of the V. A. [ ]

Except where prior approval of the [chief medical director or his designate] is required under the provisions of this paragraph, admissions to other Government, private, State, or municipal hospitals may be authorized by chief medical officers or their designates in regional offices and [centers] and by managers of insular offices.

(E) Women war veterans, needing treatment, in a medical emergency, for a condition either service connected or not service connected, may be authorized admission to a private hospital not under contract, if a Government or private contract facility is not feasibly available. [ ] In these medically emergent cases the authority for admission to a private hospital not under contract will also be authority for payment of vouchers covering necessary services or supplies furnished in accordance with the stipulations specified in subparagraph (B) (2) hereof. [ ]

(F) Managers of regional offices and [centers] through chief medical officers or their designates, are empowered to authorize admission to private hospitals, under



contract, of women war veterans suffering from nonservice-connected diseases or injuries, as well as service-connected conditions, in a medical emergency or otherwise; [ ] Provided, That a Government facility is not feasibly available; the condition of such beneficiary, if already so hospitalized, will not safely allow of her transfer to a Government facility; or the relative travel involved in admission to a Government facility, the medical condition existing, or the nature of the treatment required, make it advisable or economical to utilize the contract facility.

(G) Pregnancy and childbirth will not entitle to hospitalization, either in facilities under direct and exclusive jurisdiction of the V. A., or in other Government, private, municipal or State hospitals.

(H) The prior approval of the [chief medical director or his designate] must be secured for the use of private, State or municipal facilities covered by contracts, and located either within the continental limits of the United States or in the insular possessions or territories, for the hospitalization in such facilities of beneficiaries in excess of the number of beds contracted for, except where immediate hospitalization is indicated for treatment of a medically emergent service-connected disease or injury. The number of beds set apart by agreements with other Government facilities, for treatment of V. A. beneficiaries may be exceeded during any month as necessitated; Provided, That the utilization thereof be correspondingly reduced in other months, so that the average monthly use of such beds, at the end of the fiscal year, will not have exceeded the total allocation.

(I) An applicant whose eligibility for hospitalization (whether for observation or treatment, or whether for a service-connected or nonservice-connected condition) had been determined, whose admission to a Government facility had been authorized and who had been supplied transportation therefor, but who, while en route to the designated facility (or en route from it after completion of service and regular discharge, to the point from which he had proceeded to the hospital), develops an unavoidable and unforeseen medical emergency that forbids continuance of such travel and requires admission to a private hospital or treatment by a private physician, will be entitled to such necessary services at the expense of the Government, including any extra transportation costs (ambulance or otherwise) that were actually necessitated in the circumstances. (1) If the chief medical officer or his designate of the territory concerned is informed of such emergency hospital admission or such physician's treatment before or shortly after the beginning of the services, authorization for the services, followed by payment of bills therefor, may be made in accordance with the terms of (B) (2). (2) If the chief medical officer or his designate had not authorized such hospitalization or such physician's services, he may nevertheless certify for payment bills from the hospital superintendent or the attending physician, provided determination is made of the actual necessity for the items of service rendered, and payment is at fees provided in the schedule of fees, V. A. (3) Subject to the same controlling conditions as in (2), the chief medical officer or his designate may authorize reimbursement of the beneficiary or his representative if either had paid bills submitted by the superintendent of the hospital or by the physician who had attended the beneficiary, and had submitted those receipted bills. (April 22, 1946.)

6051. HOSPITALIZATION IN MEDICAL EMERGENCIES.--Prior authority must always be obtained for travel incident to hospital treatment or domiciliary care. Ordinarily such authority will be issued when a veteran is notified of approval of his application, and transportation, meal and lodging requests, as necessitated, are sent to him or his representative. But when an applicant's condition is medically emergent, authority for travel may be extended by telephone or telegraph, subject to the procedure provided therefor. (February 23, 1938.)

(6) Persons pursuing a course of vocational training authorized under Public Law 16, 78th Congress, who are in need of treatment to avoid interruption of such training.

(7) Persons properly referred by authorized officials of other Federal agencies for which the Administrator of Veterans Affairs may agree to render such service under conditions stipulated by him and pensioners of nations allied with the United States in World War I and World War II when duly authorized. Charges for treatment of patients of the classes specified herein will be at prescribed rates.

(8) Employees of the VA, their families, and the general public in emergencies, subject to conditions stipulated by the Administrator of Veterans Affairs. Charges for treatment of patients specified herein will be at prescribed rates.

(B) While outpatient treatment is primarily authorized only for service-connected or service-aggravated conditions, adjunct outpatient treatment for a nonservice-connected condition which is associated with and held to be aggravating disability from a disease or injury service connected or service aggravated may be also authorized in accordance with prescribed principles for persons defined in subparagraphs (A) (1) through (5) above. The opinion of the Branch Medical Director may be requested in any individual case where advice as to the propriety of furnishing adjunct treatment is desired. (January 1, 1948)

[6062. CHARGES FOR PERSONS INELIGIBLE FOR SERVICES AT VA EXPENSE.--Charges for medical services, dental services, or domiciliary care, including necessary medicines, orthopedic or prosthetic appliances, and other supplies furnished by the VA to persons not entitled thereto under laws bestowing such benefits to veterans will be made at such rates as may be fixed by the Administrator of Veterans Affairs.] (April 5, 1948)

## HOSPITAL DISCHARGE OF ACTIVELY TUBERCULOUS PATIENTS

### 6065. STATUTORY DISCHARGE

(A) Beneficiaries with active tuberculosis, the disability from which has been adjudicated as attributable to service in World War I who have been hospitalized for a continuous period of 1 year under proper medical supervision; whose condition, it is adjudged, will not reach arrest by further hospitalization; and whose discharge from hospital treatment will not be prejudicial to themselves or their families, will be potentially eligible for the statutory hospital discharge authorized in section 202 (3), World War Veterans' Act, 1924, as provided by Public No. 141, 73d Congress. (See medical procedure.) (September 25, 1945)



(B) Actively tuberculous patients whose discharge from hospital treatment under subparagraph (A) above is not disapproved by the Chief Medical Officer or Clinical Director will be so discharged if proper investigation by the office concerned discloses the following necessities of home environment: A sanitary domicile where reasonable comforts and care can be provided, such as a well-ventilated room or porch, good food, fresh air, etc.; relatives or friends who can assume the obligations of continued nursing care, who know how properly to safeguard themselves from infection by proper disposition of the patient's sputum, and who can furnish, on forms supplied by the VA, the information necessary for administrative supervision; feasibility of keeping infants and young children from infection by the patient; facilities to provide for not less than 18 hours a day in bed or in a "curing chair."

(C) Discharge, not under Public No. 141, 73d Congress, where there has not been 1 year's continuous hospitalization. Beneficiaries suffering from active tuberculosis who have not had 1 year's continuous hospitalization under proper medical supervision but who fulfill all other conditions specified in subparagraph (A) hereof may be permitted discharge from hospital treatment for "maximum benefit" but not under the provisions calling for the post-hospital statutory award in section 202 (3), World War Veterans' Act, 1924, as provided by Public No. 141, 73d Congress. If there is probability of further improvement of these patients by hospitalization, it will be continued. (December 1, 1937)

## DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL TREATMENT OR DOMICILIARY CARE

### 6066. AUTHORITY FOR DISCIPLINARY ACTION

(A) The good conduct of beneficiaries receiving hospitalization for observation and examination or for treatment, or receiving domiciliary care in facilities under direct and exclusive jurisdiction of the VA, will be maintained by corrective and disciplinary procedure formulated by the VA. Such corrective and disciplinary measures, to be selectively applied in keeping with the comparative gravity of the particular offense, will consist, in respect to hospital patients, of the withholding for a determined period of pass privileges, exclusion from entertainments, or disciplinary discharge; and, in respect to domiciled members, such penalties as confinement to barracks or grounds, deprivation of privileges, performance of extra duty without pay for a stated period, enforced furlough, or dropping from rolls.

(B) Discharge for infraction of hospital discipline will carry the accompanying penalty of exclusion from rehospitalization except in a medical emergency, and from domiciliation, for a prescribed period, with denial of Government transportation to cover return travel upon such discharge or to

cover rehospitalization in a medical emergency, unless the offender executes affidavit of inability to defray the expenses of such travel. Likewise, exclusion from domiciliary care for a stated period will exclude an offender from hospital treatment (except in a medical emergency) for such stated period.

(C) The penalties prescribed in subparagraph (B) above will be applicable to those persons receiving hospitalization in other Government or private facilities as beneficiaries of the VA and members of State soldiers' homes on whose behalf said home is receiving Federal aid payments, who are discharged therefrom for an offense similar in nature for which the VA would give an irregular discharge if such persons had been patients or members in a VA hospital or center. (January 1, 1948)

(Paragraph 6066 continued.)





## REIMBURSEMENT FOR LOSS BY FIRE OF PERSONAL EFFECTS OF HOSPITALIZED PATIENTS

6075. CONDITIONS OF CUSTODY.--When the personal effects of a patient who has been or is hospitalized in a VA hospital or center were or are duly delivered to a designated location for custody and loss of such personal effects has occurred or occurs by fire, either during such storage or during laundering, reimbursement will be made as provided in the following paragraphs 6076 and 6077. (April 22, 1946)

6076. SUBMITTAL OF CLAIM FOR REIMBURSEMENT.--The claim for reimbursement for personal effects damaged or destroyed will be submitted by the patient to the supply officer. The patient will separately list and evaluate each article with a notation as to its condition at the time of the fire, i.e., whether new, worn, etc. The date of the fire will be stated. It will be certified by a responsible official that each article listed was stored in a designated location at the time of loss by fire or was in process of laundering. He will further state whether the loss of each article was complete or partial, permitting of some further use of the article. The supply officer will certify that the amount of reimbursement claimed on each article of personal effects is not in excess of the fair value thereof at time of loss. The certification will be prepared in triplicate, signed by the responsible officer who made it, and countersigned by the Manager of the hospital or center. After the above papers have been secured, voucher will be prepared, signed, and certified, and forwarded to the finance officer for his approval, payment to be made in accordance with finance procedure. The original list of property and certificate are to be attached to voucher. (April 22, 1946)

6077. CLAIMS IN CASES OF INCOMPETENT PATIENTS.--Where the patient is insane and incompetent, he will not be required to make claim for reimbursement for personal effects lost by fire as required under the provisions of the foregoing paragraph. The responsible official will make claim for him, adding the certification in all details as provided for in the foregoing paragraph. After countersignature of this certification by the Manager, payment will be made as provided for in the foregoing paragraph, and the amount thereby disbursed will be turned over to the Manager for custody. (April 22, 1946)

[Paragraphs 6080, 6081, 6082, 6083, 6084, 6085, 6086, 6087, 6088, 6089, 6093, 6094, and 6095 canceled July 12, 1948.]

ACCOUNTS OF SALES AND COLLECTIONS.--See R&P 4797.





## TRANSPORTATION OF CLAIMANTS AND BENEFICIARIES

6100. Transportation at Government expense may be supplied eligible claimants and beneficiaries of the V. A. for these purposes:

(A) (1) Hospital admission of applicants under R. & P. R-6047 (A) and (B), for treatment of service-connected conditions.

(2) Hospital admission of applicants under R. & P. R-6047 (C) and (D) for treatment of nonservice-connected conditions, provided [such applicants, except those whose admission is arranged to prevent interruption of training authorized under Public No. 16, 78th Congress, as amended] have made sworn statement upon application, Form P-10, that they are unable to defray expense of transportation.

(3) Hospital admission for observation and examination.

(4) Admission for domiciliary care of applicants under R. & P. R-6047 (C), [(2) and (D)], provided applicants have made sworn statement of inability to defray expense of transportation.

(B) Readmissions - (1) Hospital readmissions, when medically determined necessary to observe progress, modify treatment or diet, etc. (2) The furnishing of transportation incident to readmission for domiciliary care will require prior consent of the [branch medical director or his designate]. (3) No transportation will be furnished a person whose period of exclusion from hospital treatment or domiciliary care for infraction of [ ] discipline has not expired, except when emergent hospital treatment is required, and the applicant executes affidavit that he is unable to defray the expense of transportation to accomplish travel [for readmission] for such emergent hospital treatment.

(C) Transfer - [Inter-station transfers for treatment, diagnosis or domiciliary care. Prior consent of the branch medical director or his designate will be had for transfers of patients en bloc within the branch area, and of both branch medical directors or their designates if inter-branch transfers are involved. Transfers from hospital treatment to domiciliary care, will require prior consent of the branch medical director or his designate.]

(D) Discharge - (1) Upon completion of hospitalization for treatment, or for observation and examination, and regular discharge, return transportation to the point from which the beneficiary had proceeded; or to another point if no additional expense be so caused the Government. (2) [A patient in a terminal condition may be discharged to his home, or transferred to a hospital] suitable and nearest his home, regardless, whether travel so required exceeds that covered in proceeding to the [hospital] of original admission. (3) The furnishing of transportation to effect discharge of a member from domiciliary care will require prior consent of the [branch medical director or his designate]. (4) No return transportation will be supplied a patient who receives an irregular discharge from hospital treatment, unless he executes an affidavit of inability to defray expense of return transportation.

(E) Out-patient physical examination, subject to exceptions defined in (G).

(F) Out-patient treatment - for service-connected conditions, including adjunct treatment thereof, [and for nonservice-connected conditions to prevent interruption of training authorized under Public No. 16, 78th Congress, as amended], subject to exceptions defined in (G).

(G) (1) Claimants or beneficiaries residing in the city or town where their out-patient examination is to be made or out-patient treatment rendered, or in such proximity to such city or town that it may be considered their place of residence,



will not be furnished transportation for such out-patient service, except that a station vehicle may be used or expense of common carrier transportation allowed, when the fare involved exceeds ten cents each way, and the [deputy administrator of the branch area involved] approves the exercise of this special authority at selected points. (2) Transportation for out-patient treatment will not be supplied an applicant whose period of exclusion from hospital treatment or domiciliary care for a disciplinary offense has not expired. (3) No return transportation will be supplied a claimant or beneficiary who has not completed an out-patient service, unless he executes an affidavit that he is unable to defray the expense of such travel.

(H) All travel for the foregoing purposes, (A) to (F), must be authorized in advance. In emergent hospital admissions, such prior authority may be given by telephone or telegraph, subject to confirmation in writing by the authorizing employee.

(I) The accessories of transportations - meals and lodging en route, Pullman accommodations and accompaniment by an attendant or attendants - may be authorized when determined necessary for the travel.

(J) In furnishing transportation and other expenses incident thereto, as defined, the V. A. may (1) issue requests for transportation, meals and lodging; or (2) reimburse the claimant, beneficiary or representative for payment made for such purpose, upon due certification of vouchers submitted therefor; or (3) make mileage allowance.

(K) Transportation of beneficiaries of other Federal agencies, incident to medical services rendered upon requests of those agencies, will not be furnished by the V. A. Transportation requests incident to medical services rendered Canadian and British Imperial pensioners will be subject to reimbursement by the [Department of Veterans Affairs], Canada. (April 15, 1946.)

## ORTHOPEDIC AND PROSTHETIC APPLIANCES

6115. (A) Orthopedic or prosthetic appliances furnished entitled beneficiaries of the V. A. will be of approved types. Repairs or replacements [of appliances of approved types] may be made, as provided, when necessitated in medical judgment, because of wear, loss not due to negligence of the beneficiaries, or for other sufficient reasons.

(B) Dental prostheses are not comprehended as orthopedic and prosthetic appliances.

(C) Beneficiaries supplied prosthetic appliances will be additionally entitled to fitting and training in the use of the appliances; and such service may be obtained under contract, if determined necessary by the [branch medical director of the area involved, or his designate]. (Section 104, Title I, Public No. 346, 78th Congress, [as amended].) (April 15, 1946.)

(D) Artificial limbs and other prosthetic or orthopedic appliances of a permanent type may be purchased, made or repaired for, and special clothing made necessary by wear of such appliances may be furnished to:

(1) Out-patients entitled to and in need of such appliances, etc., (a) for a disease or injury which is service connected; or (b) for an associated condition, not attributed to military or naval service, but held to be aggravating the disability from a service-connected disease or injury (adjunct treatment).

(2) Hospitalized patients; when medically held needed for (a) a service-connected condition; (b) an associated disease or injury held to be aggravating disability from a service-connected disorder (adjunct treatment); (c) a disease or injury, not attributed to military or naval service, for which hospitalization had been

authorized; or (d) for a condition, also not service connected, that is associated with and held to be aggravating disability from the disease or injury for which the patient had been admitted to hospital (auxiliary treatment). Repair or replacement of a previously supplied artificial limb will not be considered invariably necessitated because of surgical treatment of a stump in itself, e.g., for ulcer or neuroma. But when, because of reamputation or other treatment, or a disease process resulting in atrophy, sufficient change in the contour of the stump occurs, alteration or replacement of a socket or other part of the artificial limb, or, if necessary, the furnishing of a new limb, will be authorizable. Like authority may be exercised when, upon hospitalization of a beneficiary for treatment of a stump, it is medically determined that the artificial limb he had been wearing is defective or improperly fitted, and is creating the necessity for treatment of the stump. Alteration of the appliance or, if clearly necessary, the furnishing of a new artificial limb, may then be held a proper part of the patient's treatment. (July 25, 1944.)

(3) Domiciled members, when medically held needed for (a) a service-connected condition; (b) a disease or injury not service connected, but held to be aggravating disability from a service-connected condition (adjunct treatment); (c) appliances, [not considered for furnishing under (a) or (b) may nevertheless be procured or repaired for domiciled members, when medically determined necessary as an incident of domiciliary care.

(4) Persons pursuing a course of training under Public No. 16, 78th Congress, when medically determined as essential to prevent interruption of such training.] (December 10, 1945.)

6116. RETIRED PERSONNEL.--(A) (1) Pursuant to the provisions of Public No. 308, 78th Congress, approved May 23, 1944, an artificial limb or other appliance will be supplied [or repaired] when medically determined necessary, for any officer or enlisted man retired from the Army, Navy, Marine Corps, or Coast Guard who had lost a limb or the use thereof through injury or disease incurred or contracted in line of duty in the military or naval service at any time.

(2) No commutation in lieu of such artificial limb or other appliance will be payable on or after May 23, 1944.

(3) "Other appliances" will be taken to mean braces, etc., for support of a part in which function has been lost or much impaired.

(4) Such artificial limbs or other appliances [or repairs thereto] will be supplied at field stations in accordance with the general procedure pertaining to the furnishing of orthopedic and prosthetic appliances [ ].

[(B) Persons defined in (A) (1) who are furnished an artificial limb or other appliance will be additionally entitled to fitting and training in the use thereof. (Section 104, Title I, Public No. 346, 78th Congress).] (December 10, 1945.)

6118. GUIDE DOGS OR MECHANICAL AND ELECTRONIC EQUIPMENT FOR BLIND BENEFICIARIES.--(A) Pursuant to the provisions of Public No. 309, 78th Congress, approved May 24, 1944, blind ex-members of the armed forces entitled to disability compensation or pension for a service-connected disability may be furnished a trained seeing-eye or guide dog. In addition, they may be supplied the necessary travel expenses to and from their places of residence to the point where adjustment to the seeing-eye or guide dog is available and meals and lodging during the period of adjustment, provided they are required to be away from their usual places of residence during the period of adjustment.

(B) Mechanical and electronic equipment considered as aiding in overcoming the handicap of blindness may also be supplied beneficiaries defined in (A). (See also R. & P. 6895.) (October 27, 1944.)





## DENTAL SERVICES

6120. AUTHORIZATION OF DENTAL EXAMINATIONS--When a detailed report of dental examination is essential for a determination of eligibility for benefits, a chief, dental service, or other empowered official may authorize dental examinations for the following classes of claimants or beneficiaries:

(A) Those having a dental disability adjudicated as incurred or aggravated in military or naval service in war or peacetime, or those requiring examination to determine whether the dental disability is service connected.

(B) Those having service-connected disability from disease or injury other than dental, but with an associated and not service-connected dental condition that is considered to be aggravating the basic service-connected disorder.

(C) Those for whom a dental examination is ordered as a part of a general physical examination.

(D) Those requiring dental examination during hospital treatment or domiciliary care.

(E) Those held to have suffered dental injury or aggravation of an existing dental injury, as the result of examination, hospitalization, or medical or surgical (including dental) treatment that had been awarded.

(F) Those requiring dental examination for determination of necessity of dental treatment to prevent interruption of vocational training authorized under Public No. 16, 78th Congress.

(G) Those for whom a special dental examination is authorized by the medical director. (December 14, 1944.)

6123. AUTHORIZATION OF DENTAL TREATMENT.--Dental treatment may be authorized for the following classes of beneficiaries: .

(A) Class I - Those having service-connected compensable or pensionable dental or oral disabilities.

(B) Class II - Those having service-connected non-compensable or non-pensionable dental or oral disabilities.

(C) Class III - Those having a dental condition, not service connected, but medically determined to be aggravating disability from an associated systemic disorder that is either service connected or not service connected (see adjunct and auxiliary treatment).

(D) Class IV - Those receiving domiciliary care who require dental treatment.

(E) Class V - Those pursuing a course of vocational training authorized under Public No. 16, 78th Congress, who require dental treatment to prevent interruption of training. (See also R. & P. R-6030 and R-6060.) (December 14, 1944.)

6124. EMERGENCY DENTAL TREATMENT.--Emergency dental treatment may be authorized by a chief medical officer, clinical director, chief of service, or other full-time physician or dentist of the V. A. for beneficiaries as provided in R. & P. 6233, 6550-6554 inclusive, and 6763. Emergency dental treatment will comprehend the alleviation of pain or extreme discomfort, the adequate remediation of a dental or oral condition which is determined to be immediately endangering the life or health of the individual. Such emergency treatment which may be furnished an applicant whose prima facie eligibility therefor has been shown, but whose claim for benefits has not yet received favorable adjudication, will not in itself entitle the applicant to further dental treatment that may be indicated unless and until his eligibility for such continuous treatment is duly determined. (December 14, 1944.)



6129. EXTENT OF DENTAL TREATMENT.--The type and extent of dental treatment in any individual case will be determined by a dental officer of the V. A. in accordance with the following principles:

(A) In Class I (see R. & P. R-6123), any dental treatment indicated as reasonably necessary to retain masticatory function may be authorized.

(B) (1) In Class II, any treatment indicated as necessary for the correction of wartime service-connected dental disabilities may be authorized as well as for peacetime service-connected dental disabilities, provided the applicant was discharged under conditions other than dishonorable on account of a disability incurred in line of duty, or is in receipt of pension for a service-incurred disability. When diseased teeth (the disability from which is service connected) are to be replaced by means of artificial dentures, all other diseased teeth in the same maxilla may be extracted, if necessary, and the dentures may be constructed accordingly. This principle will also apply when extraction is indicated for mechanical reasons. But in constructing bridges for missing teeth, the loss of which has not been attributed to military or naval service, only mechanical necessity will permit consideration of such missing teeth in designing the bridge.

(2) When service connection has been established only for teeth missing from one maxilla, and artificial dentures for both jaws are determined necessary to meet proper treatment indications, extractions of teeth in the opposing maxilla may be made.

(3) Missing third molar teeth, loss of which has been attributed to military or naval service, will not be replaced; nor will such circumstances be held to call for replacement of other missing teeth whose loss is not service connected.

(C) In Class III, treatment will be rendered, as adjunct or auxiliary measures, for only those dental conditions which, in sound professional judgment, are having a direct and material detrimental effect upon an associated basic disease.

(D) In Class IV, sufficient treatment will be rendered domiciliary members to keep their mouths in hygienic and comfortable condition, with sufficient masticatory surface to maintain health.

(E) In Class V, treatment other than emergency, will consist only of such measure as may be reasonably necessary to prevent the interruption of an authorized course of vocational training. (October 2, 1945.)

[6131 and 6132 canceled May 25, 1946.]

6135. REPLACEMENT OF DENTAL PROSTHESIS.--(A) Dental prosthesis (i.e., fillings, bridges and dentures), furnished for treatment of service-connected dental disease or injury, which have been broken or become unserviceable through legitimate wear and deterioration, may be replaced, provided the condition is still shown to be service connected by the final dental rating promulgated under current rating instructions. Usually prosthesis, especially fillings and fixed bridges, should give at least two years service, and this should be considered in these cases. In average cases in which fillings and fixed bridges inserted by designated dentists fail within two years, due to faulty technique or engineering, the claimant, if practicable, will be referred back to the designated dentist who rendered the treatment, who will be required to adjust the defective prosthesis; if this cannot be done, or if the designated dentist declines to make good the defect, determination will be made by the chief, dental service, as to the advisability of requesting a refund. In considering

such cases due consideration will be given to the veterans's physical condition, and any unusual or extenuating conditions which obtain in his mouth.

When the chief, dental service, is of the opinion that a refund is in order he will prepare a brief of the facts in the case, attaching thereto copies of pertinent documents, and submit it to the finance officer with a recommendation that refund in a specified amount be effected, if possible.

(B) Dental prosthesis, such as bridges and dentures, furnished for treatment of a service-connected dental disease or injury, when lost, destroyed, or otherwise disposed of by a veteran, may be replaced upon the authority of the chief medical officer or his designate. The field station concerned will obtain affidavits of the veterans and, if possible, of other persons familiar with the circumstances of the loss, destruction, etc. The chief medical officer or his designate may require any other additional evidence considered necessary to show good faith and lack of carelessness on the part of the veteran, and may deny replacement if circumstances warrant.

(C) Dental prosthesis such as bridges and dentures furnished as adjunct or auxiliary relief, when requiring replacement through legitimate wear or deterioration, will be replaced upon determination as to the present necessity of replacement as adjunct or auxiliary relief.

(1) If the veteran applies for replacement, on an out-patient basis, of prosthesis previously furnished as adjunct treatment and cannot produce such prosthesis, the procedure as prescribed in (B) above will govern in determining eligibility thereto.

(2) If the prosthesis is indicated as adjunct or auxiliary treatment on an in-patient basis, the chief, dental service, will satisfy himself that the prosthesis previously furnished was not destroyed, lost or otherwise disposed of due to the carelessness or neglect of the beneficiary. If he is of the opinion that the loss was occasioned by the carelessness or neglect of the beneficiary, the decision as to replacement will be made by the chief medical officer or clinical director, as required in (B) above.

(D) Dental prosthesis, such as bridges and dentures furnished veterans receiving domiciliary care in a V. A. facility as Class IV (domiciliary) treatment, may be replaced when unserviceable through fair wear and deterioration. If veteran requests replacement of prosthesis previously furnished him by the V. A. and is unable to produce the prosthesis or presents same in a mutilated condition, the chief, dental service, will secure all evidence available and present it to the chief medical officer or clinical director for a determination as to whether the prosthesis was lost through the carelessness and neglect of the veteran or wilfully mutilated by him. If such determination is made, replacement will be made only upon payment of the cost of the prosthesis by the veteran either in cash, or by labor at the facility for which he will be credited at the rate of fifty cents per day. The cost of the appliance will be computed at twenty-five percent of the fee basis value shown in R. & P. A-6015.

(E) Dental prosthesis, such as bridges and dentures furnished vocational trainees, will be replaced in accordance with the same procedure as prescribed in subparagraph (C) above and subject to the provisions of R. & P. R-6129 (E). (October 2, 1945.)





## REIMBURSEMENT OR PAYMENT FOR EXPENSES OF UNAUTHORIZED MEDICAL SERVICES

6140. ADJUDICATION OF CLAIMS.--(A) Claims for reimbursement or payment of expenses of medical services obtained without prior authorization of the VA as herein-after comprehended, will be adjudicated in the office of the branch medical director [except in cases under the jurisdiction of central office which will be adjudicated in the office of the chief medical director].

(B) [Chief medical officers of regional offices and centers with regional office activities upon receiving such claims will be required to develop them as hereinafter instructed (R. & P. R-6148 (A), (B)), before forwarding them to the office of the branch medical director or the chief medical director, central office. Claims for services rendered in foreign countries will be developed in the out-patient administration division, central office.]

(C) [Claims not exceeding \$500 in amount will be reviewed and approved or disapproved by the chief or assistant chief of the out-patient division of each branch office or by the chief or assistant chief of the out-patient administration division, office of the chief medical director, central office. If the claim exceeds \$500 in amount the recommendation for approval will be submitted by the chief or assistant chief, out-patient division in the branch office, to the branch medical director or by the assistant medical director for auxiliary services, central office, to the chief medical director or his designate.]

[(D)] Appeals - Claims, as defined in R. & P. R-6141 will be subject to one review after an adverse decision, upon appeal to the Administrator. Appeals must be entered within one year from the date of notification to the claimant or his representative of the original adverse decision and the claimant or representative will be so advised. No claim that had been finally denied prior to March 20, 1933, will be reopened or reconsidered. A claim will be deemed to have been finally denied when (1) Original adjudication or appellate action was taken adversely, and proper appeal was not entered prior to March 20, 1933, or within one year from the date on which the claimant was notified of the adverse action, whichever is the later date; or (2) when the claim was finally denied on appeal prior to March 20, 1933 (Public No. 307, 74th Congress). (May 15, 1947.)

6141. CLASSES OF CLAIMS COMPREHENDED.- Claims for reimbursement of or payment for medical treatment (including the necessary travel incidental thereto) obtained without prior authorization from the VA, except as provided in subparagraphs (D) and (E) hereof will be considered under the following conditions: (July 9, 1946.)

(A) The claim must be for treatment of a service-connected disease or injury only; or for the adjunct relief of an associated nonservice-connected condition determined as aggravating the disability from the basic service-connected disorder. (December 27, 1945.)

(B) As to unauthorized treatment rendered prior to March 20, 1933, the claims will be limited to cases falling within the final proviso of section 202 (9), World War Veterans' Act, 1924, as amended, viz., (1) The treatment must have been rendered in a medical emergency; (2) Government facilities must have been not feasibly available; (3) Delay would have been hazardous. All of these three elements must have existed, and if any one was lacking reimbursement or payment will not be authorized; (4) Claim must have been filed with the VA prior to March 20, 1933, as required by Public No. 307, 74th Congress, Act of August 23, 1935. (September 30, 1944.)



(C) As to [unauthorized] treatment rendered subsequent to March 19, 1933, the eligibility criteria defined in (B) (1), (2), and (3) will apply; and, in addition, it must be shown by a decision of an adjudicative agency that the disability from the disease or injury for which treatment had been rendered was service-connected, or determined by the medical officers designated in R. & P. R-6140 [(C)] as aggravating such service-connected disability. (May 15, 1947.)

(D) As to claims for reimbursement of or payment for medical treatment for a nonservice-connected disease or injury, rendered a beneficiary receiving vocational training under Public Law 16, 78th Congress, the eligibility criteria defined in (B) (1), (2), and (3) will apply; and in addition it must be shown that the treatment was necessary to prevent interruption of training. (September 30, 1944.)

(E) As to claims for reimbursement of or payment for repairs of prosthetic appliances used by beneficiaries for treatment of a service-connected disability, or a nonservice-connected disability determined as aggravating the basic service-connected disability and for repairs of prosthetic appliances used and required by beneficiaries to prevent interruption of the pursuit of a course of training authorized under Public Law 16, 78th Congress, the following eligibility criteria in lieu of those defined in (B) (1), (2), and (3) will apply:

1. The repairs were secured from locally available sources. (December 27, 1945.)

2. The cost of the repairs does not exceed \$35.00. (July 9, 1946.)

3. There is a showing that the repairs were necessary and that it was more expedient to have such repairs made through private arrangements.

Reimbursement or payment as herein provided will be made in the amount claimed unless determined unreasonable, in which event only a reasonable amount for the service rendered will be paid. Reimbursement or payment will not be made for expense incurred by a beneficiary for transportation. (December 27, 1945.)

6142. CONDITIONS CONTROLLING CLAIMS.--When the unauthorized treatment was rendered prior to June 7, 1924, no payment or reimbursement will be made for any period over which compensation had not been awarded for the service-connected disability. When the unauthorized treatment was rendered subsequent to June 7, 1924, payment or reimbursement, in accordance with the provisions of section 202 (9), World War Veterans' Act, 1924, as amended, may be allowed regardless of the compensability of the beneficiary's service-connected disability but in no case more than one year prior to the date of filing claim under section 210, World War Veterans' Act, 1924, as amended (Comptroller General's Decision A-20304, Nov. 2, 1927). (May 16, 1938.)

6143. DEFINITIONS.--(A) The term "beneficiary" as used in R. & P. R-6140 to 6148, inclusive, means:

(1) In claims for payment for or reimbursement of expenses incurred in procuring unauthorized treatment prior to March 20, 1933, any veteran of World War I, not dishonorably discharged, who after filing claim for disability compensation (application for which includes application for treatment) is determined by the VA to have had a service-connected disability entitling to treatment through the VA. (July 21, 1945.)

(2) As to claim for unauthorized treatment rendered subsequent to March 19, 1933, any veteran who at the time of such treatment was suffering from a service-connected disability.

(B) "Emergency," as used in R. & P. R-6140 to 6148, inclusive, means treatment of a condition which, in sound medical judgment, will not permit of delay without endangering the claimant's health or life.

(C) "No facilities are or were then feasibly available," as used in R. & P. R-6140 to 6148, inclusive, means that an attempt to use such facilities beforehand would not have been reasonably sound, wise or practicable, or that treatment had been or would have been denied. In applying this definition, the distance from a VA center; the location of the patient; the sex and color; the nature and degree of his disability; the available means of transportation; the season and weather conditions then prevailing; the type of medical personnel or equipment requisite; and the time the services were rendered, are elements to be given consideration.

(D) "Delay would be or would have been hazardous," as used in R. & P. R-6140 to 6148, inclusive, means the risk of possible disastrous consequences attendant upon an endeavor by the claimant to secure treatment through governmental agencies, under any or all circumstances. (September 30, 1944.)

6144. ADJUNCT TREATMENT.--Reimbursement of or payment for adjunct treatment (see R. & P. R-6141 (A) and (C)) will be allowed only when such treatment was rendered in an emergency. For such adjunct treatment rendered prior to June 7, 1924, no payment or reimbursement will be made for any period over which compensation had not been awarded for the basic service-connected disease or injury. For adjunct treatment rendered subsequent to June 7, 1924, and where claim was filed prior to March 20, 1933, payment or reimbursement therefor may be allowed regardless of the compensability of the beneficiary's basic service-connected disease or injury, but in no case more than one year prior to the date of filing claim under section 210 of the World War Veterans' Act, 1924, as amended (Public No. 307, 74th Congress). For adjunct treatment rendered subsequent to March 19, 1933, payment or reimbursement may be allowed regardless of the compensability of the beneficiary's basic service-connected disease or injury. (July 21, 1945.)

6145. STATEMENT TO SUPPORT CLAIMS.--(A) NURSING SERVICES.--To support a claim for unauthorized medical service when a nurse had been employed, a statement will be required from the attending physician showing necessity for such nurse, and whether she was a registered graduate or a so-called "practical nurse." When for any good reason, it is not practicable to procure such statements and in the judgment of the physician reviewing the claim as prescribed in R. & P. R-6140 [(C)] the need for a nurse is sufficiently established, the latter may so certify. Payment for service of a "practical nurse" will be allowed only in the exceptional cases wherein a registered graduate nurse could not be engaged.

(B) ROOM AND BOARD.--Where [in claims for services rendered prior to May 15, 1947, the fee charged for room and board exceeds \$3 per diem,] the excess will not be allowed unless there is submitted a statement from the attending physician or superintendent of the hospital concerned that the [veteran's condition demanded the use of a semi-private or private room, or in the judgment of the reviewing physician the necessity therefor is sufficiently established by the evidence of record, in which event fees of \$4.00 and \$5.00, respectively, may be allowed]. However, this provision will not prohibit approval of a fee exceeding \$5.00 in exceptional and meritorious cases.

(C) VISITS MADE OUTSIDE OF A CITY OR TOWN.--All [claims involving additional fees for] visits made outside of a town or city limits [prior to May 15, 1947,] should show the time consumed by the physician in actual travel as required by the [Schedule of Fees, VA] in effect at the time such services were rendered.



(D) PRESCRIPTIONS, [DRUGS AND LABORATORY SERVICES].--When reimbursement is claimed for prescriptions, copies of the prescriptions must be supplied, or in lieu thereof, when it is impossible to obtain the prescriptions, an itemized statement from the druggist showing the [kind and quantity] of medicines furnished may be accepted. All bills for drugs and laboratory services must be fully itemized. No lump sum charges are allowable. (May 15, 1947.)

6146. [ALLOWABLE FEES.-- (A)] In the adjudication of claims for unauthorized medical treatment [rendered prior to May 15, 1947,] the Schedule of Fees, VA, will govern as to allowance for items except as provided in R. & P. R-6141 (E). If the schedule of fees in effect at the time the treatment was rendered did not provide a fee for the particular service, the schedule in effect at the time the claim is being considered will be applied. If the particular service is not covered by the schedule in effect, a fee not in excess of what is reasonable and customarily charged in the community concerned, may be allowed.

[(B) In the adjudication of claims for unauthorized medical treatment rendered subsequent to May 15, 1947, fees charged for services may be allowed provided they are considered reasonable and not in excess of those customarily charged the general public for similar services in the locality where rendered. Claims for accommodations in a semi-private or private room must be supported by a statement from the attending physician or superintendent of the hospital concerned that the veteran's condition demanded the use of a private or semi-private room, unless in the judgment of the reviewing physician the necessity therefor is established by the evidence of record.] (May 15, 1947.)

6147. TREATMENT NOT DEPENDENT UPON PREFERENCE OF A PATIENT.--No reimbursement or payment of unauthorized medical treatment will be made when procured by a claimant through private sources in preference to available government facilities (Decisions Comptroller General, Jan. 31, 1924, A. D. 8111, Jan. 28, 1925, A-6594). No payment or reimbursement will be made for any unauthorized medical service (including incident necessary travel) under conditions other than specified in R. & P. R-6140-6148, inclusive. (May 16, 1938.)

6148. DEVELOPMENT OF CLAIMS.--(A) Guided by the controlling provisions of R. & P. R-6140-6147, inclusive, the chief, out-patient [administration division, central office;] the chief medical officer, regional offices and the physician in charge of regional office medical activities at centers or their physician designate will advise claimants whether they have or have not prima facie eligibility to reimbursement or payment of unauthorized medical expenses. If the claim is patently inadmissible (e. g., if made for treatment of a nonservice-connected disability, etc.) the claimant will be so advised and the claim will not be developed. But if the basic facts indicate prima facie eligibility, the [employees aforementioned will instruct the claimant as to the submission of VA Form 10-583, if not originally filed and all the supporting exhibits. After these have been checked as satisfactory they will be forwarded with the claimant's files (claims and medical treatment) to the branch office of jurisdiction or to central office if it has been determined that the case is under the jurisdiction of that office, for adjudication. In claims comprehended under R. & P. R-6141 (E), a resume of the pertinent evidence of record will suffice in lieu of the files.]

(B) Formal application for reimbursement or payment of unauthorized medical services will be made on [VA Form 10-583,] Claim for Cost of Unauthorized Medical services. This form will be executed by each creditor who has rendered service for which pay-

ment has not been received; or by each person who has paid, from his personal funds, the cost of the unauthorized medical treatment. The claim must be supported by completely itemized bills or statements of account. When a claim is presented by a creditor, it is further required that a statement be supplied, signed by the patient or his representative, certifying to the amounts due and unpaid.

(C) All claims other than those patently inadmissible will be briefed by the claims examiner (medical) [in central office and branch offices] prior to their submittal, with supporting exhibits and the beneficiaries' files to the [employees defined in R. & P. R-6140 (C)] for approval or disapproval. The brief will contain a complete description of the claim, all pertinent facts explanatory of the data required in [VA Form 10-608, Public Voucher,] and an explanation of the audit of the amounts claimed and amounts allowable.

(D) Upon approval of claims an award will be prepared on adjudication [VA Form 10-608,] Public Voucher, in quadruplicate. The original [VA Form 10-608] will be signed in the spaces provided by the claims examiner (medical) as "medical claims adjudicator" and the employee designated in R. & P. R-6140 [(C)] acting in the capacity of medical claims authorizer. The original [(VA Form 10-608)] and two copies [(VA Form 10-608a)] will be forwarded to the branch director of finance service for certification for payment [in branch office cases or to the office of the assistant administrator for finance if central office has jurisdiction]. In view of such certification surety bonds will not be required for medical claims authorizers. The remaining copy [(VA Form 10-608a), VA Form 10-583,] the approved brief of facts, all bills, supporting exhibits and correspondence will be filed in the case file. The payee and all interested persons will be fully informed of the action taken. (May 15, 1947.)

(E) In problem or doubtful claims the advice of the chief medical director may be solicited by the submission of a brief of the pertinent facts, and a concise statement of the question at issue. (July 9, 1946.)






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